EDI Billing
User Guide

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Version 1.8

Department of Veterans Affairs (VA)
Office of Enterprise Development (OED)

Revision History

Date	Revision	Description	Author
August 2005	1	Patch IB*2*296	M. Simons
July 2006	1.1	Patch IB*2*320	M. Simons
February 2007	1.2	Patches IB*2*343, 348 and 349	C. Smith M. Simons
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February 2009	1.6	Patch IB*2*400	M. Simons
November 2010	1.7	Patch IB*2*436 – Section 4 and Section 4.5.3.1 Also replaced references to Emdeon and Express Bill with "clearinghouse"	M. Simons B. Anderson
January 2011	1.8	Edits by Training Department and removed reference to patch IB*2*433	B. Anderson

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1. INTRODUCTION

In 1996, Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act directs the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. Now that these standards are in place, the Veterans Health Administration (VHA) will submit claims containing the required standard data content to all payers accepting electronic data interchange (EDI).

1.1. Revenue Process

The overall patient billing revenue process for the VHA is summarized in the table below:

Revenue Cycle

Intake	UR	Billing	Collection	UR
Patient Registration Insurance Identification Insurance Verification	Pre-certification & Certification Continued Stay	Documentation EDI Bill Generation MRA Claim status messages	Establish Receivables A/R Follow-up Lockbox Collection Correspondence	Appeals

During the Intake phase, the patient is registered. Insurance information is identified and/or verified.

In the Utilization Review phase, the patient is pre-certified and certified, and continued stay reviews are performed.

In the Billing phase, the patient encounter is documented and coded. An electronic data interchange (EDI) bill and/or Medicare Remittance Advice (MRA) request is generated and sent to the payer. Claim status messages include information that appears on the Claims Status Awaiting Resolution (CSA) report.

During the Collections phase, establishment of receivables, accounts receivables follow-up, lockbox, and any collection correspondence take place.

Another Utilization Review can take place if there are any appeals.

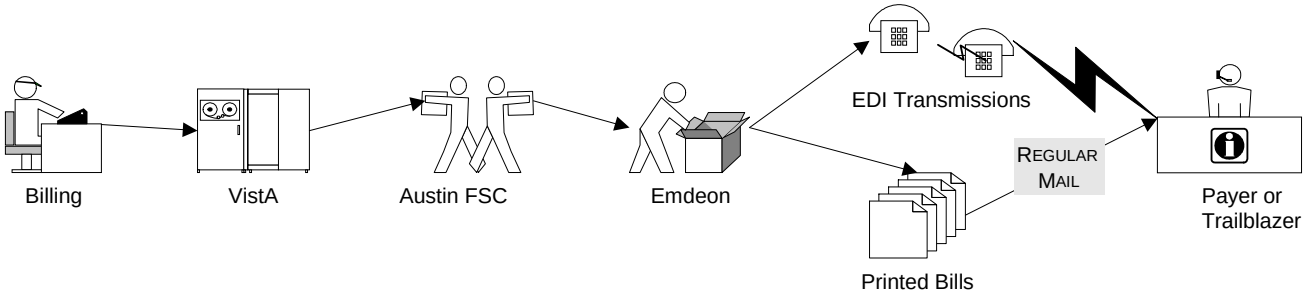
EDI Billing provides the VHA with the capability to submit electronic Institutional & Professional claims, rather than printing and mailing claims from each facility.

1.2. Critical EDI Process Terms

- 835 - The HIPAA adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The term “835” represents the data set that is sent from health plans to health care providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term “835” is used interchangeably with electronic remittance advice (ERA) and Medicare remittance advice (MRA).
- 837 - The HIPAA adopted standard for electronic submission of hospital, outpatient and dental claims. The term “837” represents the data set that is sent from health care providers to insurance companies (payers). The 837 standard includes the data required for coordination of benefits and is used for primary and secondary payer claims submission. The term “837” is used interchangeably with electronic claim.
- Claim Status Message – Electronic messages returned to the VAMC providing status information on a claim from the Financial Service Center (FSC) in Austin, Texas. These messages can originate at FSC, at the payer or at the Clearinghouse.
- Clearinghouse - A company that provides batch and real-time transaction processing services and connectivity to a payer or provider. Transactions include insurance eligibility verification, claims submission processing, electronic remittance processing and payment posting for electronic claims.
- eClaim - A claim that is transmitted to FSC electronically.
- EDI – Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility.
- EOB – An Explanation of Benefits (EOB) reports the disposition of an individual claim. Many EOBs may be contained within a single 835 Electronic Remittance Advice (ERA) file.
- ePayer - Payer that accepts electronic claims from the clearinghouse.
- Fiscal Intermediary – A fiscal intermediary performs services on behalf of health care payers. These services include claim adjudication, reimbursement and collections. Trailblazer Health Enterprises is an example of a fiscal intermediary that acts on behalf of Medicare. Trailblazer receives claims from the VA in the form of an 837 file and then adjudicates the claims to create a MRA 835 file.
- FSC – The Financial Service Center (Austin, Texas) receives 837 claims transmissions from VistA and transmits this data to the clearinghouse. FSC also receives error/informational messages and 835 data from the clearinghouse and transmits this data to VistA.

- HIPAA – In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards thus eliminating all non-standard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.

1.3. EDI Process Flow



The above flowchart (EDI Process Flow) represents the path electronic claims follow. The objective of electronic billing is to submit completely correct claims. Claims sent electronically reach the payer faster, are processed faster, and are paid faster than claims submitted on paper via the mail.

From the user's desktop, the claim goes to the FSC in Austin, TX as a VistA Mailman message. The FSC translates the claim into the HIPAA 837 format and forwards it to the clearinghouse.

From the clearinghouse, the arrow pointing upwards represents the path claims travel if they can be submitted electronically to the payer. If the clearinghouse does not have an electronic connection with a payer or if specific claims must be submitted on paper, the claim is printed and mailed to the payers.

Electronic claims status messages from ePayers return to the VAMCs along the same path. Payers receiving printed claims do not return electronic messages. However, the clearinghouse will return a message indicating that the claim was printed and mailed.

Different electronic edits are in place at each transmission point that may initiate the sending of a claims status message. Claim status messages returned by the

clearinghouse and/or payer will provide information on a specific claim. There is no standard content for messages. The information contained within a claim status message varies from payer to payer.

2. INSURANCE COMPANY SET-UP

The most common cause of claims rejection is the improper setup of the insurance company and/or provider IDs within VistA. With EDI Billing, there are fields in an 837 claim transmission that are auto-populated with the data defined in VistA. This information must be accurate to generate a clean electronic claim.

2.1. Insurance Company Setup

2.1.1 Activate New Payer To Transmit eClaims

The typical business process for setting up new payers is:

1. The Insurance Verification Office initially enters a new payer into VistA.
2. Lists of new payers are printed and provided to the medical center's billing office on a regular basis (daily/weekly). Some individuals become members of the IB New Insurance mail group so they receive e-mail bulletins whenever a new insurance policy is added to VistA.
3. Billing staff use the Insurance Company Editor to define Provider IDs: Type of Coverage; Electronic Insurance Type and Electronic Transmit? by Insurance Company. The Profession/Institutional Payer Primary and Secondary IDs are also defined using the Insurance Company Editor.
4. Billing staff use the Insurance Company Editor to specify the correct Electronic Plan Type for each Insurance Plan.

Selecting the correct electronic plan type is important. This field may determine which provider IDs are transmitted and/or printed. Choosing the wrong electronic plan type for an Insurance Plan could result in claims being rejected by the clearinghouse or by the payer.

2.1.1.1 Define EDI settings for a Blue Cross/Blue (BC/BS) Shield Insurance Company.

Step	Procedure
1	At the Billing Parameters screen in the Insurance Company Editor, enter **BP – Billing/EDI Param**.

```
Insurance Company Editor      Oct 01, 2007@10:15:14          Page:    1 of    9
Insurance Company Information for: BLUE CROSS
Type of Company: HEALTH INSURANCE                    Currently Active

                          Billing Parameters
  Signature Required?: NO                      Filing Time Frame:
           Reimburse?: WILL REIMBURSE           Type Of Coverage: HEALTH INSURAN
    Mult. Bedsections:                             Billing Phone: 800/933-9146
     Diff. Rev. Codes:                        Verification Phone: 800/933-9146
       One Opt. Visit: NO                     Precert Comp. Name:
  Amb. Sur. Rev. Code:                             Precert Phone: 800/274-7767
  Rx Refill Rev. Code:


                              EDI Parameters
               Transmit?: NO                        Insurance Type:
+          Enter ?? for more actions                                          >>>
BP  Billing/EDI Param     IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen//BP  Billing/EDI Param
```

The following prompts will display.

```
SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS:
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY:
AMBULATORY SURG. REV. CODE:
PRESCRIPTION REFILL REV. CODE:
FILING TIME FRAME:
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 800/933-9146//
VERIFICATION PHONE NUMBER: 800/933-9146//
Are Precerts Processed by Another Insurance Co.?:
PRECERTIFICATION PHONE NUMBER: 800/274-7767//
EDI - Transmit?: NO// YES-LIVE
EDI - Inst Payer Primary ID: 12B30
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: SB960
EDI - 1ST Prof Payer Sec. ID Qualifier:
         // EDI - Insurance Type: GROUP POLICY
EDI - Bin Number: ......................
```

Step	Procedure
	*Patch IB*2.0*320 added a new security key, **IB EDI INSURANCE EDIT**. A user must hold this key to edit the EDI-Transmit, EDI Prof Payer ID; EDI Inst Payer ID and EDI-Insurance Type fields.*
2	At the **EDI - Transmit?**: prompt, enter **1** to change the field to **YES-LIVE**.
3	At the **EDI - Inst Payer Primary ID**: prompt, enter the **Payer Primary ID** provided by the clearinghouse.

When editing the Payer Primary ID fields for a commercial payer, (not BC/BS) these fields may be left blank. The clearinghouse will try to match the VistA payer name and address to an entry in its Payer Lookup Table and auto-populate these fields. Payer ID numbers are available at https://access.emdeon.com/PayerLists/.

4 At the **EDI - 1ST Inst Payer Sec. ID Qualifier**: prompt, press **Return** to leave field blank.

*Patch IB*2*371 added the ability to define Payer Secondary IDs. They are unusual and should only be populated if the clearing house or CBOprovides you with a secondary ID number.*

5 At the **EDI - Prof Payer Primary ID**: prompt, enter the **Payer Primary ID** provided by the clearinghouse.

6 At the **EDI - 1ST Prof Payer Sec. ID Qualifier**: prompt, press **Return** to leave field blank.

7 At the **EDI - Insurance Type**: prompt, enter **??** to see the choices available. For this example, select **Group Policy**. This will result in a checkmark in the GROUP insurance box of the CMS-1500/BOX 1.

8 Press the **Return** key until the Billing Parameters screen reappears.

*When Patch IB*2*371 is loaded, the patch will automatically define a Professional Payer Secondary for Medicare WNR that will have a Qualifier = Payer ID Number and an ID = VA plus the site's ID.*

```
EDI - Transmit?: YES-LIVE//
EDI - Inst Payer Primary ID: 12M61//
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: SMTX1//
EDI - 1ST Prof Payer Sec. ID Qualifier: PAYER ID #
        //
EDI - 1ST Prof Payer Sec. ID: VA442//
```

2.1.1.2 Define EDI settings for a Blue Cross/Blue Shield Group Insurance Plan:

Step	Procedure
1	At the Billing Parameters Screen in the Insurance Company Editor, enter **VP - View Plans** and press the **Return** key.

```
Insurance Company Editor      Oct 01, 2007@10:15:14          Page:    1 of    9
Insurance Company Information for: BLUE CROSS
Type of Company: HEALTH INSURANCE                    Currently Active

                           Billing Parameters
  Signature Required?: NO                      Filing Time Frame:
           Reimburse?: WILL REIMBURSE           Type Of Coverage: HEALTH INSURAN
    Mult. Bedsections:                            Billing Phone: 800/933-9146
     Diff. Rev. Codes:                         Verification Phone: 800/933-9146
       One Opt. Visit: NO                      Precert Comp. Name:
  Amb. Sur. Rev. Code:                              Precert Phone: 800/274-7767
  Rx Refill Rev. Code:


                              EDI Parameters
               Transmit?: YES-LIVE                Insurance Type: GROUP POLICY
+          Enter ?? for more actions                                        >>>
BP  Billing/EDI Param     IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen//VP  View Plans
```

Step	Procedure
2	The Insurance Plan List appears. In this example, Plan 1 is selected by typing **VP=1** and pressing the **Return** key.

```
Insurance Plan List            Mar 31, 2004@16:12:52          Page:    1 of    1
All Plans for: BLUE CROSS BLUE SHIELD DEMO Insurance Company

#  + => Indiv. Plan    * => Inactive Plan                      Pre-  Pre-  Ben
    Group Name          Group Number       Type of Plan   UR?  Ct?   ExC?  As?
1   DEMO FOR TRAINING   87654              COMPREHENSIVE  NO   YES   YES   YES



          Enter ?? for more actions
VP  View/Edit Plan                      IP  (In)Activate Plan
AB  Annual Benefits                     EX  Exit
Select Action: Quit// VP=1
```

Step	Procedure
3	The View/Edit Plan screen appears. To edit plan information, type **PI** and press the **Return** key.

```
View/Edit Plan                  Mar 31, 2004@16:19:51          Page:    1 of    3
Plan Information for: BLUE CROSS  Insurance Company
                                        ** Plan Currently Active **

  Plan Information                          Utilization Review Info
    Is Group Plan: YES                             Require UR: NO
       Group Name: DEMO FOR TRAINING         Require Amb Cert: YES
     Group Number: 87654                     Require Pre-Cert: YES
     Type of Plan: COMPREHENSIVE MAJOR MED   Exclude Pre-Cond: YES
   Plan Filing TF:                         Benefits Assignable: YES

  Plan Coverage Limitations
   Coverage             Effective Date   Covered?       Limit Comments
   --------             --------------   --------       --------------
   INPATIENT            02/10/04         YES
   OUTPATIENT           02/10/04         YES
   PHARMACY             02/10/04         NO
+         Enter ?? for more actions
PI  Change Plan Info                    IP  (In)Activate Plan
UI  UR Info                             AB  Annual Benefits
CV  Add/Edit Coverage                   CP  Change Plan
PC  Plan Comments                       EX  Exit
Select Action: Next Screen// PI   Change Plan Info
```

Step	Procedure
4	For this scenario **NO** is typed in for the **Do you wish to change this plan to an Individual Plan?** field.
5	Continue to press the **Return** key until **Electronic Plan Type** field is displayed.
6	Type in the appropriate code and press the **Return** key. The chosen plan will be displayed. In this example **BL** has been selected.

*Selecting the correct electronic plan type is critical. The electronic plan type for BC/BS payers should usually be set to **BL** - not commercial. Choosing the wrong electronic plan type for a Group Insurance Plan could result in claims being rejected by the clearinghouse or by the payer.*

*Note: Patch IB*2*436 added the ability to define an additional plan type for MediGap F and G plans. MEDIGAP (SUPPL - COINS, DED, PART B EXC)*

```
This plan is currently defined as a Group Plan.
Do you wish to change this plan to an Individual Plan? NO
No change was made.

GROUP PLAN NAME: DEMO GROUP//
GROUP PLAN NUMBER: 7878787878//
TYPE OF PLAN: COMPREHENSIVE MAJOR MED
ELECTRONIC PLAN TYPE: ?
Enter the appropriate type of plan to be used for electronic billing.
     Choose from:
       16        HMO MEDICARE
       MX        MEDICARE A or B
       TV        TITLE V
       MC        MEDICAID
       BL        BC/BS
       CH        TRICARE
       15        INDEMNITY
       CI        COMMERCIAL
       HM        HMO
       DS        DISABILITY
       12        PPO
       13        POS
       ZZ        OTHER
ELECTRONIC PLAN TYPE: BL BCBS
```

The following screen will display.

```
View/Edit Plan                 Mar 31, 2004@16:19:51          Page:    1 of    3
Plan Information for: BLUE CROSS Insurance Company
                                        ** Plan Currently Active **

  Plan Information                          Utilization Review Info
    Is Group Plan: YES                             Require UR: NO
       Group Name: DEMO FOR TRAINING         Require Amb Cert: YES
     Group Number: 87654                     Require Pre-Cert: YES
     Type of Plan: COMPREHENSIVE MAJOR MED   Exclude Pre-Cond: YES
   Electronic Type: BC/BS                    Benefits Assignable: YES



+         Enter ?? for more actions

Select Action: Next Screen//
```

2.1.2 Activate Existing Commercial Payer To Transmit eClaims

To activate a payer to receive electronic claims, use the Billing Parameters screen in the Insurance Company Editor. The **EDI - Transmit?** field on this screen must be set to **YES-LIVE.** In the Live mode, bills are automatically sent electronically and cannot be printed until the confirmation of a receipt message has been received from the FSC.

Follow these steps to change the **EDI - Transmit?** Field:

Step	Procedure
1	On the Billing Parameters screen in the Insurance Company Editor, type **BP** and press the **Return** key.

```
Insurance Company Editor      Oct 01, 2007@10:40:16          Page:    1 of    8
Insurance Company Information for: AETNA
Type of Company: HEALTH INSURANCE                     Currently Inactive

                          Billing Parameters
  Signature Required?: NO                      Filing Time Frame: 12 MOS
           Reimburse?: WILL REIMBURSE           Type Of Coverage: HEALTH INSURAN
    Mult. Bedsections:                             Billing Phone:
     Diff. Rev. Codes:                         Verification Phone:
       One Opt. Visit: NO                      Precert Comp. Name:
  Amb. Sur. Rev. Code:                             Precert Phone:
  Rx Refill Rev. Code:


                          EDI Parameters
              Transmit?: NO                      Insurance Type:
+         Enter ?? for more actions                                        >>>
BP  Billing/EDI Param     IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen//BP Billing/EDI Param
```

Step	Procedure
	*Patch IB*2.0*320 added a new security key, **IB EDI INSURANCE EDIT**. A user must hold this key to edit the EDI-Transmit, EDI Prof Payer ID; EDI Inst Payer ID and EDI-Insurance Type fields.*
2	At the **EDI - Transmit?** field, type **1** to change the field to **YES-LIVE**.
3	At the **EDI - Insurance Type** field, enter the correct response for the Insurance Company being edited. For this example, the correct Electronic Insurance Type is **Group**.
	Except for the testing of Primary BC/BS and some secondary end to end claims, it is no longer necessary to change the **EDI - Transmit?** field to **YES-TEST**. Instead, use the new option, **RCB – View/Resubmit Claims-Live or Test**. Refer to **Section 4**.

```
SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS: YES//
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY: NO//
AMBULATORY SURG. REV. CODE:
PRESCRIPTION REFILL REV. CODE: 253//
FILING TIME FRAME: ONE YEAR//
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 800-555-5298//
VERIFICATION PHONE NUMBER: 800-555-5298//
Are Precerts Processed by Another Insurance Co.?: NO
         //
PRECERTIFICATION PHONE NUMBER: 800-555-7799//
EDI - Transmit?: ??
        This is the flag that says whether or not an insurance company is ready
        to be billed electronically via 837/EDI functions.

     Choose from:
       0        NO
       1        YES-LIVE
       2        YES-TEST
EDI - Transmit?: 1  YES-LIVE
EDI - Inst Payer Primary ID: Available from the clearinghouse
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: Available from the clearinghouse
EDI - 1ST Prof Payer Sec. ID Qualifier:
EDI - Insurance Type: ??
     Choose from:
       1        HMO
       2        COMMERCIAL
       3        MEDICARE
       4        MEDICAID
       5        GROUP POLICY
       9        OTHER
EDI - Insurance Type: 5 GROUP POLICY
BIN NUMBER:
```

The following steps show you how to enter the Electronic Plan Type for a **Commercial Group Insurance Plan**:

Step	Procedure
1	At the Billing Parameters Screen in the Insurance Company Editor type in **VP** (View Plans) and press the **Return** key.

```
Insurance Company Editor      Oct 01, 2007@10:40:16          Page:    1 of    8
Insurance Company Information for: AETNA
Type of Company: HEALTH INSURANCE                     Currently Inactive

                          Billing Parameters
  Signature Required?: NO                      Filing Time Frame: 12 MOS
           Reimburse?: WILL REIMBURSE           Type Of Coverage: HEALTH INSURAN
    Mult. Bedsections:                             Billing Phone:
     Diff. Rev. Codes:                         Verification Phone:
       One Opt. Visit: NO                      Precert Comp. Name:
  Amb. Sur. Rev. Code:                             Precert Phone:
  Rx Refill Rev. Code:


                             EDI Parameters
              Transmit?: YES-LIVE                Insurance Type: GROUP POLICY
+          Enter ?? for more actions                                        >>>
BP  Billing/EDI Param     IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen//VP  View Plans
```

Step	Procedure
2	The Insurance Plan List appears. In this example, Plan 1 is selected by typing **VP=1** and pressing the **Return** key.

```
Insurance Plan List            Apr 14, 2004@09:21:12          Page:    1 of    1
All Plans for: AETNA Insurance Company

#  + => Indiv. Plan    * => Inactive Plan                      Pre-  Pre-  Ben
    Group Name          Group Number       Type of Plan   UR?  Ct?   ExC?  As?
1   MANAGED CHOICE      55555-111-00001    COMPREHENSIVE  YES  YES   UNK   YES



          Enter ?? for more actions
VP  View/Edit Plan                      IP  (In)Activate Plan
AB  Annual Benefits                     EX  Exit
Select Action: Quit// VP=1
```

Step	Procedure
3	The View/Edit Plan screen appears. To edit plan information, type **PI** and press the **Return** key.

```
View/Edit Plan                  Apr 14, 2004@09:22:11          Page:    1 of    3
Plan Information for: AETNA Insurance Company
                                        ** Plan Currently Active **

  Plan Information                          Utilization Review Info
    Is Group Plan: YES                             Require UR: YES
       Group Name: MANAGED CHOICE                Require Amb Cert:
     Group Number: 55555-111-00001               Require Pre-Cert: YES
     Type of Plan: COMPREHENSIVE MAJOR MED       Exclude Pre-Cond:
   Plan Filing TF:                           Benefits Assignable: YES

  Plan Coverage Limitations
   Coverage             Effective Date   Covered?       Limit Comments
   --------             --------------   --------       --------------
   INPATIENT            02/01/04         YES
   OUTPATIENT           02/01/04         YES
   PHARMACY             02/01/04         NO
+         Enter ?? for more actions
PI  Change Plan Info                     IP  (In)Activate Plan
UI  UR Info                              AB  Annual Benefits
CV  Add/Edit Coverage                    CP  Change Plan
PC  Plan Comments                        EX  Exit
Select Action: Next Screen// PI   Change Plan Info
```

Step	Procedure
4	For this scenario, **NO** is entered for the **Do you wish to change this plan to an Individual Plan?** field.
5	Continue to press the **Return** key until **Electronic Plan Type** field is activated.
6	Type in the appropriate code and press the **Return** key. The chosen plan will be displayed. In this example **CI** has been selected.

Selecting the correct electronic plan type is important. Choosing the wrong electronic plan type for a Group Insurance Plan could result in claims being rejected by the clearinghouse or by the payer.

```
This plan is currently defined as a Group Plan.
Do you wish to change this plan to an Individual Plan? NO
No change was made.

GROUP PLAN NAME: MANAGED CHOICE//
GROUP PLAN NUMBER: 55555-111-00001//
TYPE OF PLAN: COMPREHENSIVE MAJOR MEDICAL//
ELECTRONIC PLAN TYPE: ?
Enter the appropriate type of plan to be used for electronic billing.
     Choose from:
       16        HMO MEDICARE
       MX        MEDICARE A or B
       TV        TITLE V
       MC        MEDICAID
       BL        BC/BS
       CH        TRICARE
       15        INDEMNITY
       CI        COMMERCIAL
       HM        HMO
       DS        DISABILITY
       12        PPO
       13        POS
       ZZ        OTHER
ELECTRONIC PLAN TYPE: CI  COMMERCIAL
PLAN FILING TIME FRAME: .....
```

The following screen will display.

```
View/Edit Plan                Apr 14, 2004@09:24:02          Page:    1 of    3
Plan Information for: AETNA DEMO INSURANCE Insurance Company
                                      ** Plan Currently Active **

  Plan Information                        Utilization Review Info
    Is Group Plan: YES                            Require UR: YES
       Group Name: MANAGED CHOICE           Require Amb Cert:
     Group Number: 55555-111-00001          Require Pre-Cert: YES
     Type of Plan: COMPREHENSIVE MAJOR MED  Exclude Pre-Cond:
  Electronic Type: COMMERCIAL             Benefits Assignable: YES



+         Enter ?? for more actions

Select Action: Next Screen//
```

2.1.3 Activate Existing Payer To Test Primary Blue Cross/Blue Shield eClaims

Blue Cross and Blue Shield payers require the submission of test claims before accepting live claims. Contact the EDI Implementation Manager at the clearinghouse to coordinate this testing.

When testing the electronic submission of secondary claims using the RCB – View/Resubmit Claims-Live or Test, it is not necessary to change Electronic Transmit? to YES-TEST nor is it necessary to print and mail claims sent using RCB.

To enable a BC/BS payer to receive primary claims electronically but in a testing mode, use the Billing Parameters screen in the Insurance Company Editor. The **EDI - Transmit?** field on this screen must be set to **YES-TEST.** In testing mode, bills are automatically sent electronically and cannot be printed until the confirmation of receipt message has been received from the FSC.

The following steps show you how to change the **Electronic Transmit?** field:

Step	Procedure
1	On the Billing Parameters screen in the Insurance Company Editor type **BP** and press the **Return** key.

```
Insurance Company Editor      Oct 01, 2007@10:15:14          Page:    1 of    9
Insurance Company Information for: BLUE CROSS
Type of Company: HEALTH INSURANCE                     Currently Active

                           Billing Parameters
  Signature Required?: NO                        Filing Time Frame:
           Reimburse?: WILL REIMBURSE             Type Of Coverage: HEALTH INSURAN
    Mult. Bedsections:                               Billing Phone: 800/933-9146
     Diff. Rev. Codes:                          Verification Phone: 800/933-9146
       One Opt. Visit: NO                       Precert Comp. Name:
  Amb. Sur. Rev. Code:                               Precert Phone: 800/274-7767
  Rx Refill Rev. Code:


                           EDI Parameters
              Transmit?: NO                          Insurance Type:
+          Enter ?? for more actions                                          >>>
BP  Billing/EDI Param      IO  Inquiry Office         EA  Edit All
MM  Main Mailing Address   AC  Associate Companies    AI  (In)Activate Company
IC  Inpt Claims Office     ID  Prov IDs/ID Param      CC  Change Insurance Co.
OC  Opt Claims Office      PA  Payer                  DC  Delete Company
PC  Prescr Claims Of       RE  Remarks               VP  View Plans
AO  Appeals Office         SY  Synonyms              EX  Exit
Select Action: Next Screen//BP  Billing/EDI Param
```

Step	Procedure
2	At the **EDI - Transmit?** field, type **2** to change the field to **YES-TEST**. Continue to press the **Return** key until the Billing Parameters screen reappears.

*When using the TEST mode setting for BC/BS claims for which payment is expected, it is important to note the carrier will not process bills sent in test mode. These bills **must be printed locally and mailed** in order to receive payment.*

```
SIGNATURE REQUIRED ON BILL?: NO//
REIMBURSE?: WILL REIMBURSE//
ALLOW MULTIPLE BEDSECTIONS: YES//
DIFFERENT REVENUE CODES TO USE:
ONE OPT. VISIT ON BILL ONLY: NO//
AMBULATORY SURG. REV. CODE: 490//
PRESCRIPTION REFILL REV. CODE: 250//
FILING TIME FRAME: ONE YEAR FROM DATE OF SERVICE
TYPE OF COVERAGE: HEALTH INSURANCE//
BILLING PHONE NUMBER: 205-988-2213//
VERIFICATION PHONE NUMBER: ITS:800-253-9307//
Are Precerts Processed by Another Insurance Co.?: NO
         //
PRECERTIFICATION PHONE NUMBER: 800-248-2342//
EDI - Transmit?: NO// ??
        This is the flag that says whether or not an insurance company is
ready to be billed electronically via 837/EDI functions.

     Choose from:
       0        NO
       1        YES-LIVE
       2        YES-TEST
EDI - Transmit?: YES-TEST//
EDI - Inst Payer Primary ID: Available from the clearinghouse
EDI - 1ST Inst Payer Sec. ID Qualifier:
EDI - Prof Payer Primary ID: Available from the clearinghouse
EDI - 1ST Prof Payer Sec. ID Qualifier:
EDI - Insurance Type: 5 GROUP POLICY
BIN NUMBER:
```

3. PAY-TO PROVIDER(S) SET-UP

Each VA database can have one or more Pay-to Providers. Each VA database must have at least one Pay-to Provider. A Pay-to Provider is the entity which is seeking payment for a claim (who will receive the payment). The Pay-to Provider does not have to have a physical location. It can have a street address or a Post Office Box number.

3.1. Define Default Pay-to Provider

Step	Procedure
1	Access the option **SITE→MCCR Site Parameter Display/Edit**.
2	From the **MCCR Site Parameters** screen, enter the action, **IB Site Parameters**.
3	Press **Return** for Next Screen until Page 2 is displayed.
4	From the **IB Site Parameters** screen, enter the action, **EP Edit Set**.
5	Enter the number **10**.
6	From the **Pay-to Providers** screen, enter the action, **AP Add Provider**.
7	From the **Enter Pay-to Provider:** prompt, enter **CHEYENNE VAMC** for this example.
	*Note: A Pay-to Provider should be a VAMC level facility with a valid NPI. The Pay-to Provider can be an institution outside your own database. Example: VAMC A could process payments for services provided by VAMC B.*
8	At the **Are you adding 'CHEYENNE VAMC' as a new PAY-TO PROVIDERS (the 1ST for this IB SITE PARAMETERS)? No*//*** prompt, enter **YES** for this example.
9	At the **Pay-to Provider Name** prompt, press return to accept the default name from the Institution file.
10	At the **Pay-to Provider Address Line 1** prompt; press **Return** to accept the default address from the Institution file.
11	At the **Pay-to Provider Address Line 2** prompt; press **Return** to accept the default address from the Institution file.
12	At the **Pay-to Provider City** prompt; press **Return** to accept the default City from the Institution file.
13	At the **Pay-to Provider State** prompt; press **Return** to accept the default State from the Institution file.
14	At the **Pay-to Provider Zip Code** prompt; press **Return** to accept the default ZIP from the Institution file.
15	At the **Pay-to Provider Phone Number** prompt; enter the **Phone Number** that a payer should use to contact the site.
16	At the **Pay-to Provider Federal Tax ID Number** prompt; press **Return** to accept the default Tax ID.
	*Note: There will be a default Tax ID only when the institution selected as the Pay-to Provider is the same as the main division in the site's database. This is taken from the IB Site Parameters.*
	*Do not add your site's Tax ID if the Pay-to Provider is another VAMC. Make sure to get and enter the other site's Tax ID.*

Note: A Pay-to Provider does not have to have an actual street address. You may enter a P.O. Box as an address.

```
Pay-To Providers             Dec 22, 2008@13:58:13          Page:    1 of    1
            No Pay-To Providers defined.









          * = Default Pay-to provider
AP  Add Provider          DP  Delete Provider       EX  Exit
EP  Edit Provider         AS  Associate Divisions
Select Item(s): Quit// AP   Add Provider
Enter Pay-to Provider: CHEYENNE VAMC   WY  M&ROC     442
  Are you adding 'CHEYENNE VAMC' as a new PAY-TO PROVIDERS (the 1ST for this IB
SITE PARAMETERS)? No// y  (Yes)
Pay-to Provider Name: CHEYENNE VAMC//
Pay-to Provider Address Line 1: 2360 E PERSHING BLVD
           Replace
Pay-to Provider Address Line 2: Mail Stop 10234
Pay-to Provider City: CHEYENNE//
Pay-to Provider State: WYOMING//
Pay-to Provider Zip Code: 82001-5356//
Pay-to Provider Phone Number: 555-555-5555
Pay-to Provider Federal Tax ID Number: 83-0168494//
```

The following screen will display.

```
Pay-To Providers             Dec 22, 2008@14:38:21          Page:    1 of    1
 1.    *Name     : CHEYENNE VAMC                    State   : WY
       Address 1: 2360 E PERSHING BLVD              Zip Code: 82001-5356
       Address 2:                                   Phone   :
       City     : CHEYENNE                          Tax ID  : 83-0168494









          * = Default Pay-to provider
AP  Add Provider          DP  Delete Provider       EX  Exit
EP  Edit Provider         AS  Associate Divisions
Select Item(s): Quit//
```

When the first Pay-to Provider is entered, it becomes the default Pay-to Provider and all the divisions in the database are assigned automatically to the default provider.

Step	Procedure
17	From the **Pay-to Providers** screen, enter the action, **AS Associate Divisions**.

The following screen will display.

```
Pay-To Provider Associations Dec 22, 2008@14:42:27          Page:    1 of    1
 CHEYENNE VAMC  (Default)
       1     442GA     CASPER
       2     442GC     FORT COLLINS
       3     442GD     GREELEY
       4     442       CHEYENNE VAMROC
       5     442GB     SIDNEY
       6     442GE     TEST MORC




          Enter ?? for more actions
AS  Associate Division                  EX  Exit
Select Item(s): Quit//
```

3.2. Associate Divisions with non-Default Pay-to Provider

When adding a second Pay-to Provider, users will be prompted to make it the default Pay-to Provider, `Is this the default Pay-To Provider? NO//.` If users make the new Pay-to Provider the default provider, all divisions will be associated with the new default. If users do not make the new provider the default, then they will have to associate select divisions with the new Pay-to Provider.

Step	Procedure
	Note: When there is more than one Pay-to Provider, users must associated divisions with the non-default Pay-to Provider(s).
1	From the **Pay-to Providers** screen, enter the action, **AS Associate Divisions**.

```
Pay-To Providers             Dec 22, 2008@14:55:32          Page:    1 of    1
 1.   *Name     : CHEYENNE VAMC                        State   : WY
       Address 1: 2360 E PERSHING BLVD                Zip Code: 82001-5356
       Address 2:                                     Phone   :
       City     : CHEYENNE                            Tax ID  : 83-0168494

 2.    Name     : MONTANA HEALTH CARE SYSTEM - FT. H State   : MT
       Address 1: VA Medical Center                   Zip Code: 59636
       Address 2:                                     Phone   : 666-666-6666
       City     : FORT HARRISON                       Tax ID  : 11-1111111




          * = Default Pay-to provider
AP  Add Provider          DP  Delete Provider       EX  Exit
EP  Edit Provider         AS  Associate Divisions
Select Item(s): Quit// AS Associate Divisions
```

The following screen will display.

```
Pay-To Provider Associations Dec 22, 2008@15:32:45          Page:    1 of    1
 CHEYENNE VAMC  (Default)
       1     442GA     CASPER
       2     442GC     FORT COLLINS
       3     442GD     GREELEY
       4     442       CHEYENNE VAMROC
       5     442GB     SIDNEY
       6     442GE     TEST MORC

 MONTANA HEALTH CARE SYSTEM - FT. HARRISON DIVISION
       No Divisions found.



          Enter ?? for more actions
AS  Associate Division                  EX  Exit
Select Item(s): Quit// AS Associate Division
Select Division (1-6): 5
Select Pay-To Provider: Montana
```

Step	Procedure
2	At the **Select Item(s):** prompt, enter the action, **AS Associate Divisions**.
3	At the **Division (1-6):** prompt, enter **5** for this example.
4	At the **Pay-to Provider:** prompt, enter **Montana** for this example.

Note: Users can not associate a division that is defined as a Pay-to Provider, to another Pay-to Provider. Users will get the following error if they try: `A division used as a Pay-to Provider can not be associated with another Pay-to Provider.`

5	Repeat steps 2 - 4 if necessary.

Note: Once a division has been explicitly associated with a particular Pay-to Provider, changing the default Pay-to Provider will not automatically change the division's associated Pay-to Provider.

The following screen will display.

```
Pay-To Provider Associations Dec 22, 2008@15:34:39          Page:    1 of    1
 CHEYENNE VAMC  (Default)
       1     442GA     CASPER
       2     442GC     FORT COLLINS
       3     442GD     GREELEY
       4     442       CHEYENNE VAMROC
       5     442GE     TEST MORC

 MONTANA HEALTH CARE SYSTEM - FT. HARRISON DIVISION
       6     442GB     SIDNEY




          Enter ?? for more actions
AS  Associate Division                  EX  Exit
Select Item(s): Quit//
```

4. PROVIDER ID SET-UP

Payers require the use of a variety of provider identifiers on claims submitted for adjudication. Printed claim forms have boxes where these IDs can be printed.

The general term, Provider ID, can refer to an ID that belongs to a human being such as an Attending physician or it can refer to an ID that belongs to an organization that provides healthcare services to a veteran such as a VAMC or an outside laboratory. Both VA and non-VA people and organizations have IDs.

IDs have qualifiers that identify what type of ID is being transmitted. An Attending physician's primary ID is his/her Social Security Number (SSN). This SSN is transmitted with a qualifier (34) which indicates that this number is an SSN. A Blue Cross ID is transmitted with a qualifier (1A) which indicates that this number is a Blue Cross number. Appendix C has a list of qualifiers and which ones can be transmitted in which 837 records.

The NPI (National Provider Identifier) is a Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirement with a usage requirement date beginning May 23, 2007. It is transmitted on 837 records along with treating specialty taxonomies from the National Uniform Claims Committee (NUCC) published code list.

Patch IB*2.0*343 added the ability to define the National Provider Identifier (NPI) and Taxonomy Codes for the VAMC, Non-VA facilities and both VA and Non-VA human providers.

Patches IB*2.0*348 and 349 added the ability to print the NPI on the new UB-04 and CMS-1500 claim forms.

After Patch IB*2*436, old claims can be reprinted locally for legal purposes and sent to Regional Counsel even though the original claim was created prior to the requirement for providers to have an assigned NPI. A legal claim is defined as having a Billing Rate Type of "NO FAULT INS", "WORKERS' COMP", or "TORT FEASOR".

Eventually, when all payers are prepared to accept the NPI, the NPI will become a provider's primary ID. In the interim, both the NPI and the legacy IDs will be transmitted to the clearinghouse and printed on locally printed claims.
The HIPAA 837 transaction set includes a number of segments in which to transmit multiple IDs and qualifiers for a single claim. The list below indicates the VistA record name, the type of information being transmitted, the maximum number of IDs that can go in that record for one claim and if the IDs will print on a paper claim (P), transmit electronically (T), or do both (B).

Segment	Type of ID	Max # of IDs	(P)rint (T)ransmit (B)oth
PRV:9	Billing Provider Primary ID (Federal Tax Number)	1	B

PRV1:6	Pay-to Provider Primary ID (Federal Tax Number)	1	T
CI1A:2-17	Billing Provider Secondary IDs	8	B
OPR1	Attending, Other or Operating Physician Primary ID	1/Physician	B
OPR1	Rendering or Referring Provider Primary ID	1/Provider	B
OPR7	Supervising Provider's Primary ID	1/Provider	B
OPR2	Attending Physician or Rendering Provider Secondary ID	5	B
OPR3	Operating Physician Secondary IDs	5	B
OPR4	Other Physician Secondary IDs	5	B
OPR5	Referring Provider Secondary IDs	5	B
OPR8	Supervising Provider Secondary IDs	5	B
NPI	National Provider Identifier (Pay-to Provider, Billing Provider, Service Facility and Performing Providers)	1/Provider	B
SUB	Laboratory or Facility Primary ID	1	B
SUB1	Purchased Service Secondary IDs	5	T
SUB2	Laboratory or Facility Secondary IDs	5	T

4.1. Table of IDs

The following table shows where IDs are defined in VistA; where they are stored in VistA; where they appear on billing forms; and where they appear in the VistA option View/Print EDI Bill Extract Data (VPE) and the EDI 837 transaction record location.

Pay-to Provider NPI	
VistA Option	The Institution file is not available to Billing personnel
VistA File	Institution (#4)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 18
Pay-to Provider Primary ID (Federal Tax Number of the VAMC) - Legacy	
VistA Option	MCCR Site Parameter Display/Edit
VistA File	IB SITE PARAMETERS (#350.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	PRV1, Piece 6
Billing Provider NPI	
VistA Option	The Institution file is not available to Billing personnel
VistA File	Institution (#4)
UB-04	FL 56
CMS -1500	Box 33a (Box 32a unless there is an outside facility)
VPE (837 Record)	NPI, Piece 12
Billing Provider Taxonomy Code	
VistA Option	The Institution file is not available to Billing personnel
VistA File	Institution (#4)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 13
Billing Provider Primary ID (Federal Tax Number of the VAMC) - Legacy	
VistA Option	MCCR Site Parameter Display/Edit
VistA File	IB SITE PARAMETERS (#350.9)
UB-04	FL 5
CMS-1500	Box 25
VPE (837 Record)	PRV, Piece 9
Billing Provider Secondary IDs - Legacy	
Note: If none are defined, the default is the Federal Tax ID.	
VistA Option	Insurance Company Entry/Edit→ID Prov IDs/ID Param
VistA File	FACILITY BILLING ID (#355.92)
UB-04	FL 57
CMS -1500	Box 33b
VPE (837 Record)	CI1A, Pieces 2-17

VA - Attending, Other or Operating Physician NPI

VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON (#200)
UB-04	FL 76-79
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 2, 4, or 6

VA – Attending, Other or Operating Physician Taxonomy Code

VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User Person Class Edit
VistA File	PERSON CLASS (#8932.1)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 3, 5, or 7

VA - Attending, Other or Operating Physician Primary ID (SSN) - Legacy

VistA Option	Add a New User to the System Edit an Existing User
VistA Files	NEW PERSON (#200)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	OPR1, Pieces 3, 6, or 9

VA - Rendering or Referring Provider NPI

VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON (#200)
UB-04	N/A
CMS-1500	Box 17b (Referring), 24J (Rendering)
VPE (837 Record)	NPI, Piece 2 or 10

VA - Rendering or Referring Provider Taxonomy Code

VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User Person Class Edit
VistA File	PERSON CLASS (#8932.1)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 3 or 11

VA – Rendering or Referring Provider Primary ID (SSN) - Legacy

VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User
VistA Files	NEW PERSON (#200)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	OPR1, Pieces 3 or 12

VA - Supervising Provider NPI

VistA Option	Provider Self Entry (Not available to Billing personnel) Add/Edit NPI values for Providers
VistA File	NEW PERSON file #200
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 8

VA - Supervising Provider Taxonomy Code

VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User Person Class Edit
VistA File	PERSON CLASS file #8932.1
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 9

VA – Supervising Provider Primary ID (SSN) - Legacy

VistA Option	Add a New User to the System (Not available to Billing personnel) Edit an Existing User
VistA Files	NEW PERSON (#200)
UB-04	N/A
CMS -1500	N/A
VPE (837 Record)	OPR7, Piece 7

Non-VA - Attending, Other or Operating Physician NPI

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA File	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	FL 76-79
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 2, 4, or 6

Non-VA - Attending, Other or Operating Physician Taxonomy Code

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA File	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	FL 76-79
CMS -1500	N/A
VPE (837 Record)	NPI, Piece 3, 5 or 7

Non-VA – Attending, Other or Operating Physician Primary ID (SSN)) - Legacy

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB BILLING PRACTITIONER ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR1, Pieces 3, 6, or 9

Non-VA – Rendering or Referring Provider NPI

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	17b (Referring), 24J (Rendering)
VPE (837 Record)	NPI, Piece 2 or 10

Non-VA – Rendering or Referring Provider Taxonomy Code

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON/OTHER VA BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	NPI, Piece 3 or 11

Non-VA – Rendering or Referring Provider Primary ID (SSN) - Legacy

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB BILLING PRACTITIONER ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR1, Pieces 3 or 12

Non-VA – Supervising Provider NPI

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	NPI, Piece 8

Non-VA – Supervising Provider Taxonomy Code

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB NON VA/OTHER BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	NPI, Piece 9

Non-VA – Supervising Provider Primary ID (SSN) - Legacy

VistA Option	Provider ID Maintenance→Non/Other VA Provider→Individual
VistA Files	IB BILLING PRACTITIONER ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR7, Piece 7

VA - Attending, Other or Operating Physician Secondary IDs - Legacy

VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 76-79
CMS-1500	N/A
VPE (837 Record)	OPR2, OPR3, OPR4 Pieces 3, 5, 7, 9 or 11

VA – Rendering or Referring Provider Secondary IDs - Legacy

VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A

CMS-1500	Box 17a (Referring), Box 24J
VPE (837 Record)	OPR2, OPR5, Pieces 3, 5, 7, 9 or 11

VA – Supervising Provider Secondary IDs - Legacy

VistA Option	Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR 8, Pieces 3, 5, 7, 9 or 11

Non - VA - Attending, Other or Operating Physician Secondary IDs - Legacy

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	FL 76-79
CMS-1500	N/A
VPE (837 Record)	OPR2, OPR3, OPR4 Pieces 3, 5, 7, 9 or 11

Non - VA – Rendering or Referring Provider Secondary IDs - Legacy

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A
CMS-1500	FL 17a (Referring), 24J (Rendering)
VPE (837 Record)	OPR2, OPR5, Pieces 3, 5, 7, 9 or 11

Non - VA – Supervising Provider Secondary IDs - Legacy

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information Provider ID Maintenance→ Provider Specific IDs→ Provider's Own IDs Provider IDs Furnished by Insurance Co
VistA Files	IB Billing Practitioner ID (#355.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	OPR8, Pieces 3, 5, 7, 9 or 11

VA - Service Facility – Laboratory or Facility NPI

After Patch IB*2*400, only VA facility types that do <u>not</u> have NPIs (e.g. MORC) will be used as VA Service Facilities. Most often the Service Facility will be blank.

VA - Service Facility – Laboratory or Facility Taxonomy Code

VistA Option	The Institution file is not available to Billing personnel
VistA File	INSTITUTION (#4)
UB-04	N/A
CMS-1500	N/A

VPE (837 Record)	NPI, Piece 17

VA - Service Facility – Laboratory or Facility Primary ID (Federal Tax ID)

VistA Option	MCCR Site Parameter Display/Edit Insurance Company Entry/Edit
VistA File	IB SITE PARAMETERS (#350.9)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	SUB, Piece 9 and SUB2, Piece 6

VA - Service Facility – Laboratory or Facility Secondary IDs - Legacy

VistA Option	Insurance Company Entry/Edit →ID Prov IDs/ID Param →VA-Lab/Facility IDs
VistA File	FACILITY BILLING ID (#355.92)
UB-04	N/A
CMS-1500	Box 32b
VPE (837 Record)	SUB1, Pieces 3, 5, 7, 9, and 11 and SUB2, Pieces 8, 10, 12, 14, 16

Non-VA - Service Facility – Laboratory or Facility NPI

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Facility Info
VistA File	IB NON VA/OTHER BILLING PROVIDER file #355.93
UB-04	N/A
CMS-1500	Box 32a
VPE (837 Record)	NPI, Piece 16

Non-VA - Service Facility – Laboratory or Facility Primary ID (Federal Tax ID) - Legacy

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Provider Info
VistA File	IB NON/OTHER VA BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	SUB, Piece 9 and SUB2, Piece 6

Non-VA - Service Facility – Laboratory or Facility Taxonomy Code

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Facility Info
VistA File	IB NON/OTHER VA BILLING PROVIDER (#355.93)
UB-04	N/A
CMS-1500	N/A
VPE (837 Record)	NPI, Piece 17

Non-VA - Service Facility – Laboratory or Facility Secondary IDs - Legacy

VistA Option	Provider ID Maintenance→ Non/Other VA Provider ID Information→Facility→Secondary ID Maint
VistA File	IB BILLING PRACTITIONER ID (#355.9)
UB-04	Not Printed
CMS-1500	32b
VPE (837 Record)	SUB1, Pieces 3, 5, 7, 9, and 11 and SUB2, Pieces 8, 10, 12, 14, 16

4.2. Pay-to Provider IDs

4.2.1 Define the Pay-to Provider Primary ID/NPI

The Pay-to Provider NPI will not be entered or maintained by Billing personnel. The Pay-to Provider NPI is retrieved from the Institution file (#4).

The Pay-to Provider Primary legacy ID is the Federal Tax Number of the site defined as the Pay-to Provider. The Federal Tax Number is defined when the Pay-to Provider is defined. Refer to **Section 3.1.**

4.2.2 Define the Pay-to Provider Secondary IDs

With Patch IB*2*400, the CI1B segment was added to the outbound 837 claim transmission map to transmit Pay-to Provider Secondary IDs if the need should arise in the future. There is currently no place in VistA IB to define Pay-to Provider Secondary IDs.

4.3. Billing Provider IDs

The Billing Provider Primary ID and the Billing Provider Secondary IDs are IDs which identify the facility at which the patient service was provided. This is a facility with a physical location (street address). The Billing Provider on a claim must be one of the following Facility Types which have been assigned NPI numbers:

- CBOC – Community Based Outpatient Clinic
- HCS – Health Care System
- M&ROC – Medical and Regional Office Center
- OC – Outpatient Clinic (Independent)
- OPC – Out Patient Clinic
- PHARM – Pharmacy
- VAMC – VA Medical Center
- RO-OC – Regional Office – Outpatient Clinic

When care is provided at any other facility type (i.e. a mobile unit), the Billing Provider will be the Parent facility as defined in the Institution file (#4) and the mobile unit will become the Service Facility.

4.3.1 Define the Billing Provider Primary ID/NPI

For all claims generated by the VA, the Billing Provider Primary legacy ID is always the Federal Tax Number of the site. Once defined, the IB software will automatically assign this ID to a claim.

Eventually, the Billing Provider NPI will become the Billing Provider Primary ID. The Billing Provider NPI is defined in the Institution file. The Federal Tax ID will become a secondary ID and payers will stop required legacy secondary IDs.

Beginning with Patch IB*2.0*343, the Billing Provider NPI will be transmitted in the 837 claim transmission along with the legacy Primary ID.

Beginning with Patches IB*2.0*348 and 349, the Billing Provider NPI will be printed on locally printed claims.

The VA Billing Provider NPI and Taxonomy Code will not be entered or maintained by Billing personnel. Users may change the default Billing Provider taxonomy code for a claim but users may not change the Billing Provider NPI.

Step	Procedure
1	Access the option **SITE→MCCR Site Parameter Display/Edit**.
2	From the **MCCR Site Parameters** screen, enter the action, **IB Site Parameters**.
3	Press **Return** for Next Screen until Page 2 is displayed.
4	From the **IB Site Parameters screen**, enter the action, **EP Edit Set**.
5	Enter the number **9**.
6	At the **Federal Tax Number** prompt, enter the site's Federal Tax Number.

```
IB Site Parameters            Oct 20, 2005@16:23:16          Page:    2 of    6
Only authorized persons may edit this data.
+
[5] Medical Center     : LOMA LINDA VAMC      Default Division   : JERRY L PETTI
    MAS Service        : PATIENT ELIGIBILITY  Billing Supervisor : KYDFES,SHUUN

[6] Initiator Authorize: YES                  Xfer Proc to Sched : NO
    Ask HINQ in MCCR   : YES                  Use Non-PTF Codes  : YES
    Multiple Form Types: YES                  Use OP CPT screen  : YES

[7] UB-04 Print IDs    : YES                  UB-04 Address Col  :
    CMS-1500 Print IDs : YES                  CMS-1500 Addr Col  : 28

[8] Default RX DX Cd   : 780.99               Default ASC Rev Cd : 490
    Default RX CPT Cd  :                      Default RX Rev Cd  : 251

[9] Bill Signer Name   : <No longer used>     Federal Tax #      :
    Bill Signer Title  : <No longer used>
    Remark on Each Bill: BILL # MUST BE ON ALL REMITTANCE

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit Action
Select Action: Next Screen// ep   Edit Set
Select Parameter Set(s):  (5-9): 9
NAME OF CLAIM FORM SIGNER: BUSINESS OFFICE//
TITLE OF CLAIM FORM SIGNER:
FEDERAL TAX NUMBER: XXX123456
```

4.3.2 Define the Billing Provider Secondary IDs

The Billing Provider Secondary IDs are IDs and Qualifiers that are provided to a site by the insurance company. There can be a total of eight Billing Provider Secondary IDs per claim. The first ID is calculated by the system and used by the clearinghouse to sort claims. The remaining seven IDs must be defined by the IB staff if required.

Users may define one Billing Provider Secondary ID for a CMS-1500 and another for a UB-04 for the main division. If no other Billing Provider Secondary IDs are defined, these two IDs will be the default IDs for all claims.

Billing Provider Secondary IDs can be defined by Division, Form Type and Care Unit.

4.3.2.1 Define Default Billing Provider Secondary IDs by Form Type

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Insurance Company Entry/Edit**.
2	At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example.
3	From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Param**.
4	From the **Billing Provider IDs screen**, enter the action **Add an ID**.
5	At the **Define Billing Provider Secondary IDs by Care Units? No// ** prompt, press **Return** to accept the default of **No**.
6	At the **Division** prompt, accept the default for the main Division.
7	At the **ID Qualifier: Electronic Plan Type//** prompt, enter **Blue Shield** to override the default value for this example.
	Note: The default value for the Billing Provider Secondary ID Qualifier is still based upon the Electronic Plan Type of the patient's insurance plan. Users now have the ability to override this default.
8	At the **Form Type** prompt, enter **CMS-1500** for this example.
9	At the **Billing Provider Secondary ID** prompt, enter the ID **XXXXXXXX1B** for this example.
10	Repeat these steps for the Form Type = **UB-04**, Qualifier = **Blue Cr**oss and ID = **XXXXXX1A**.
	Note: If no Billing Provider Secondary IDs are defined, the Federal Tax ID is used as a default value.

```
Billing Provider IDs (Parent)        May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                        ID #             Form Type

No Billing Provider IDs found



          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit// a   Add ID
Define Billing Provider Secondary IDs by Care Units? No//??

   Enter No to define a Billing Provider Secondary ID
   for the Division.
   Enter Yes to define a Billing Provider Secondary ID
   for a specific Care Unit.
   If no Care Unit is entered on Billing Screen 3, the
   Billing Provider Secondary ID defined for the Division will
   be transmitted in the claim.

       0   No
       1   Yes

Define Billing Provider Secondary IDs by Care Units? No//No
Division: Main Division// Main Division
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: CMS-1500
Billing Provider Secondary ID: XXXXXX1B
```

The following screen will display. These two IDs will be the default IDs for all claims and will appear on Billing Screen 3.

```
Billing Provider IDs (Parent)        May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                        ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                          XXXXXX1A         UB04
2    Blue Shield                         XXXXXX1B         1500




          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit//
```

4.3.2.2 Define Billing Provider Secondary IDs by Division and Form Type

If an insurance company requires different Billing Provider Secondary IDs for each division, then users must define more than just the default IDs.

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Insurance Company Entry/Edit**.
2	At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example.
3	From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Param**.
4	From the **Billing Provider IDs screen**, enter the action **Add an ID**.
5	At the **Define Billing Provider Secondary IDs by Care Units? No//** prompt, press **Return** to accept the default of **No**.
6	At the **Division** prompt, override the default for the main division by entering the name of another division, **Remote Clinic** for this example.
7	At the **ID Qualifier: Electronic Plan Type//** prompt, enter **Blue Shield** to override the default value for this example.
8	At the **Form Type** prompt, enter CMS-1500 for this example.
9	At the **Billing Provider Secondary ID** prompt, enter the ID **1XXXXX1B** for this example.
10	Repeat these steps for the Form Type = **UB-04**, Qualifier = **Blue Cross** and ID = **1XXXXX1A**.

Note: Users may repeat these steps to define different Billing Provider Secondary IDs for each division if required by the insurance company.

```
Billing Provider IDs (Parent)       May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA       Billing Provider Secondary IDs
     ID Qualifier                      ID #              Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                        XXXXXX1A          UB04
2    Blue Shield                       XXXXXX1B          1500




          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit// a   Add ID
Define Billing Provider Secondary IDs by Care Units? No//No
Division: Main Division// Remote Clinic
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: CMS-1500
Billing Provider Secondary ID: 1XXXXX1B
```

The following screen will display.

Note: The two IDs for the Remote Clinic division will be available to the clerk on Billing Screen 3 for claims for services provided by this division.

```
Billing Provider IDs          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                        ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                          XXXXXX1A         UB04
2    Blue Shield                         XXXXXX1B         HCFA

Division: Remote Clinic
3    Blue Cross                          1XXXXX1A         UB04
4    Blue Shield                         1XXXXX1B         1500



          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit//
```

4.3.2.3 Define Billing Provider Secondary IDs by Division, Form Type and Care Unit

If an insurance company requires different Billing Provider Secondary IDs for services provided by particular Care Units, users can define them by Division, Form Type and Care Unit.

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Insurance Company Entry/Edit**.
2	At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example.
3	From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Parameters**.
4	From the **Billing Provider IDs screen**, enter the action **Add an ID**.
5	At the **Define Billing Provider Secondary IDs by Care Units? No//** prompt, enter **YES** to override the default.
6	At the **Division** prompt, press **Return** to accept the default for the **Main Division**.
7	At the **Care Unit:** prompt, enter **??** to see a pick list of available Care Units.
	*Refer to **Section 3.4.2** to learn how to create this list of available Care Units.*
8	At the **Care Unit:** prompt, enter **Anesthesia** for this example.
9	At the **ID Qualifier: Electronic Plan Type//** prompt, enter **Blue Shield** to override the default value for this example.
10	At the **Form Type** prompt, enter **CMS-1500** for this example.
11	At the **Billing Provider Secondary ID** prompt, enter the ID **11XXXX1B** for this example.
12	Repeat these steps for the Form Type = **UB-04**, Qualifier = **Blue Cross** and ID = **11XXXX1A**.
13	Repeat these steps for Care Units **Reference Lab** and **Home Health**.

```
Billing Provider IDs          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                      ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                        XXXXXX1A         UB04
2    Blue Shield                       XXXXXX1B         1500

Division: Remote Clinic
3    Blue Cross                        1XXXXX1A         UB04
4    Blue Shield                       1XXXXX1B         1500


          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit// a   Add ID
Define Billing Provider Secondary IDs by Care Units? No//??

   Enter No to define a Billing Provider Secondary ID
   for the Division.
   Enter Yes to define a Billing Provider Secondary ID
   for a specific Care Unit.
   If no Care Unit is entered on Billing Screen 3, the
   Billing Provider Secondary ID defined for the Division will
   be transmitted in the claim.

       0   No
       1   Yes

Define Billing Provider Secondary IDs by Care Units? No//1  Yes
Division: Main Division// Main Division
Care Unit:??
   Select a Care Unit from the list:
       1 Anesthesia
       2 Reference Lab
       3 Home Health
Care Unit: 1   Anesthesia
ID Qualifier: Electronic Plan Type//Blue Shield
Enter Form Type for ID: CMS-1500
Billing Provider Secondary ID: 11XXXX1B
```

The following screen will display.

```
Billing Provider IDs          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA   Billing Provider Secondary IDs
     ID Qualifier                        ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                          XXXXXX1A         UB04
2    Blue Shield                         XXXXXX1B         1500
 Care Unit: Anesthesia
3    Blue Cross                          11XXXX1A         UB04
4    Blue Shield                         11XXXX1B         1500
 Care Unit: Reference Lab
5    Blue Cross                          12XXXX1A         UB04
6    Blue Shield                         12XXXX1B         1500
 Care Unit: Home Health
7    Blue Cross                          13XXXX1A         UB04
8    Blue Shield                         13XXXX1B         1500
+
          Enter ?? for more actions
    Add an ID            Additional IDs        Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Quit//
```

*If users want a default Billing Provider Secondary ID to populate Billing Screen 3, define a default ID for the division and define IDs for the division and specific care units. Users will have the ability to either accept the default ID or override it with one of the Care Unit IDs during the creation of a claim. Refer to **Section 4.1.2**.*

4.3.2.4 Define Additional Billing Provider Secondary IDs by Division and Form Type

In addition to the Billing Provider Secondary ID that appears on Billing Screen 3 for each insurance company on the bill, there can be six additional Billing Provider Secondary IDs that will be transmitted with claims for an insurance company.

Prior to Patch IB*2.0*320, the IDs defined in IB Site Parameters, Section 14 and Provider ID Maintenance, Number 3, were transmitted with all claims to all payers. These options for defining IDs were removed with Patch IB*2.0*320.

If an insurance company requires additional Billing Provider Secondary IDs, users can define them in Insurance Company Entry/Edit.

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Insurance Company Entry/Edit**.
2	At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example.
3	From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Param**.
4	From the **Billing Provider IDs screen**, enter the action **Additional IDs**.
5	From the **Billing Provider IDs – Additional Billing Provider Sec. IDs screen,**

enter the action **Add an ID**.

6 At the **ID Qualifier:** prompt, enter **Medicare** for this example.

Note: There can not be two Billing Provider Secondary IDs on a claim with the same Qualifier. If you enter an ID with the same Qualifier here as one defined under Billing Provider Secondary IDs for the Division on a claim, the Additional Billing Provider Secondary ID with the same Qualifier will not be transmitted on the claim.

7 At the **Form Type** prompt, enter **CMS-1500** for this example.

9 At the **Billing Provider Secondary ID** prompt, enter the ID **14XXXX1C** for this example.

10 Repeat these steps for the Form Type = **UB-04**, Qualifier = **Medicare**, ID = **14XXXX1C**.

Note: Users may repeat these steps to define multiple additional Billing Provider Secondary IDs if required by the insurance company.

```
Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA  Additional Billing Provider Sec. IDs
     ID Qualifier               ID #             Form Type

No Additional Billing Provider IDs found




          Enter ?? for more actions
    Add an ID           Delete an ID     Exit
    Edit an ID          Copy IDs

Select Action: Quit// Add an ID
Type of ID: Medicare
Form Type: 1500
Billing Provider Secondary ID: 14XXXX1C
```

The following screen will display.

```
Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA  Additional Billing Provider Sec. IDs
     ID Qualifier               ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Medicare                   14XXXX1C         UB04
2    Medicare                   14XXXX1C         1500




          Enter ?? for more actions
    Add an ID           Delete an ID     Exit
    Edit an ID          Copy IDs

Select Action: Quit// Add an ID
Type of ID: Medicare
Form Type: UB-04
Billing Provider Secondary ID: XXXXXXX11
```

4.4. Service Facility IDs (Laboratory or Facility IDs)

The 837 claims transmission has records that contain Service Facility data like the name and address of a facility and primary and secondary IDs for that facility. Often this is an outside, non-VA facility. These IDs are called the Laboratory or Facility Primary ID and the Laboratory or Facility Secondary IDs.

If there is a non-VA facility on a claim because a veteran received care at an outside laboratory or a private hospital or clinic, an insurance company may require the claim to contain primary and secondary Laboratory or Facility IDs for the organization that provided the care.

If there is not an outside facility on a claim, but the care was provided by the VA at a facility such as a Mobile clinic, an insurance company may require the claim to contain primary and secondary Laboratory or Facility IDs for the clinic.

Patch IB*2.0*320 provided enhancements to allow users to more easily define Laboratory or Facility IDs for the VA or non-VA.

Beginning with Patches IB*2.0*348 and 349, the Service Facility NPI will be printed on locally printed CMS-1500 claims.

Beginning with Patch IB*2.0*400, the Service Facility loop will not be populated if the care was provided at a VA location that has an NPI such as a CBOC, VAMC or Pharmacy.

The non-VA Service Facility NPI and Taxonomy Code will be entered and maintained by Billing personnel.

4.4.1 Define Non-VA Laboratory or Facility Primary IDs/NPI

For outside, non-VA facilities such as an independent laboratory, the Laboratory or Facility Primary ID should be the entity's Federal Tax ID.

In addition to the Federal Tax ID, an NPI and one or more Taxonomy Codes can be defined for outside, non-VA facilities.

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **NF** for Non-VA Facility .
3	At the **Select a NON/Other VA Provider**: prompt, enter **IB Outside Facility** for this example.
4	From the **Non-VA Lab or Facility Info screen,** enter the action **FI** for Lab/Facility Info.
5	At the **Name:** prompt, enter **IB Outside Facility** for this example.
6	At the **Street Address:** prompt, enter **123 Westbend Street** for this example.

7 At the **Street Address Line 2**: prompt, press **Return** to leave blank.
8 At the **City** prompt, enter **Long Beach** for this example.
9 At the **State**: prompt, enter **California** for this example.
10 At the **Zip Code** prompt, enter **92060** for this example.
11 At the **ID Qualifier:** prompt, press **Return** to accept the default.
12 At the **Lab or Facility Primary ID**: prompt, enter **111111112**.
13 At the **X12 Type of Facility:** prompt, enter **FA - Facility** for this example.

*With Patch IB*2*371, FA will be sent as the Type of Facility on all institutional claims regardless of what is defined. HIPAA only allows FA on institutional claims.*

14 At the **Mammography Certification Number**: prompt, press **Return** to leave it blank. If you know the Mammography number you can enter it here.
15 At the **NPI**: prompt, enter **XXXXXXXXXX** for this example.
16 At the **Select Taxonomy Code**: prompt, enter **954** for this example.
17 At the **OK?** Prompt, press **RETURN** to accept the default.
18 At the **Are you adding 'General Acute Care Hospital' as a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No//** prompt, enter **Yes**.
19 At the **Primary Code**: prompt, enter **Yes** for this example.
20 At the **Status**: prompt, enter **Active**.
21 At the **Select Taxonomy Code**: prompt, press **Return**.

```
NAME: IB OUTSIDE FACILITY//
STREET ADDRESS: 123 Test Street
STREET ADDRESS LINE 2:
CITY: CHEYENNE// Long Beach
STATE: CALIFORNIA
ZIP CODE: 82001// 92060
ID Qualifier: 24 - EMPLOYER'S IDENTIFICATION #
Lab or Facility Primary ID: 111111112//
X12 TYPE OF FACILITY: FACILITY//
MAMMOGRAPHY CERTIFICATION #:
NPI: XXXXXXXXXX
Select TAXONOMY CODE: 954  General Acute Care Hospital     282N000
00X
         ...OK? Yes//   (Yes)

  Are you adding 'General Acute Care Hospital' as
    a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No/
/ y  (Yes)
  PRIMARY CODE: y  YES
  STATUS: a  ACTIVE
Select TAXONOMY CODE:
```

The following screen will display.

```
Non-VA Lab or Facility Info   Dec 05, 2006@17:04:07          Page:    1 of    1


        Name: IB OUTSIDE FACILITY
     Address: 123 Test Street
              Long Beach, CALIFORNIA  92060

           Type of Facility: FACILITY
                 Primary ID: 111111112
              ID Qualifier: 24 - EMPLOYER'S IDENTIFICATION #
 Mammography Certification #:
                        NPI: XXXXXXXXXX
              Taxonomy Code: 261QV0200X (Primary)




         Enter ?? for more actions
FI   Lab/Facility Info                 LI   Lab/Facility Ins ID
LO   Lab/Facility Own ID               EX   Exit
Select Action: Quit//
```

4.4.2 Define Non-VA Laboratory or Facility Secondary IDs

For outside, non-VA facilities users can define multiple Laboratory or Facility Secondary IDs. These IDs can be either the facility's own IDs such as a Clinical Laboratory Improvement Amendment (CLIA) number or IDs assigned to the facility by an insurance company.

4.4.2.1 Define a non-VA Facility's Own Laboratory or Facility Secondary IDs

Step	Procedure
1	Access the option **MCCR System Definition Menu→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **NF** for Non-VA Facility .
3	From the **Non-VA Lab or Facility Info screen,** enter the action **LO** for Lab/Facility Own ID
4	From the **Secondary Provider ID** screen, enter the action **AI** for Add an ID**.**
5	At the **Enter Provider ID Qualifier** prompt, enter **X5 CLIA Number** for this example.
6	At the **Form Type Applied to**: prompt, enter **CMS-1500 FORMS ONLY** for this example.
7	At the **Care Type:** prompt, enter **OUTPATIENT ONLY** for this example.
8	At the **Enter Lab or Facility Secondary ID** prompt, enter **DXXXXX** for this example.

Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs.

```
Secondary Provider ID          May 11, 2005@11:17:20          Page:    1 of    1
           ** Lab or Facility's Own IDs (No Specific Insurance Co) **

Provider: IB Outside Facility (Non-VA Lab or Facility)

ID Qualifier               Form   Care Type                ID#
 No ID's found for provider


          Enter ?? for more actions
AI   Add an ID                           DI   Delete an ID
EI   Edit an ID                          EX   Exit
Select Action: Quit// AI Add an ID
Select Provider ID Qualifier: X5 CLIA Number
FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: OUTPATIENT ONLY

THE FOLLOWING WAS CHOSEN:
   INSURANCE: ALL INSURANCE
   PROV TYPE: CLIA #
   FORM TYPE: CMS-1500 FORM ONLY
   CARE TYPE: OUTPATIENT ONLY

Provider ID: DXXXXX
```

The following screen will display.

```
Secondary Provider ID          May 11, 2005@11:17:20          Page:    1 of    1
           ** Lab or Facility's Own IDs (No Specific Insurance Co) **

Provider: IB Outside Facility (Non-VA Lab or Facility)

     ID Qualifier                Form   Care Type     ID#
1    CLIA #                      1500   OUTPT          DXXXXX




          Enter ?? for more actions
AI   Add an ID                           DI   Delete an ID
EI   Edit an ID                          EX   Exit
Select Action: Quit//
```

4.4.2.2 Define a non-VA Facility's Laboratory or Facility Secondary IDs Assigned by an Insurance Company

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **NF** for Non-VA Facility.
3	From the **Non-VA Lab or Facility Info screen,** enter the action **LI** for Lab/Facility Ins ID.
4	From the **Secondary Provider ID** screen, enter the action **AI** for Add an ID**.**

5 At the **Enter Provider ID Qualifier** prompt, enter **Blue Shield** for this example.

6 At the **Form Type Applied to**: prompt, enter **CMS-1500 FORMS ONLY** for this example.

7 At the **Care Type:** prompt, enter **BOTH** for this example.

8 At the **Enter Lab or Facility Secondary ID** prompt, enter **111XXX1B** for this example.

Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs. A maximum of 5 Laboratory or Facility Secondary IDs can be defined per insurance company. A maximum of 5 Laboratory or Facility Secondary IDs can be transmitted in a claim.

```
Secondary Provider ID          May 11, 2005@11:17:20          Page:    1 of    1
          ** Lab or Facility Secondary IDs from Insurance Co **

Provider: IB Outside Facility (Non-VA Lab or Facility)
Insurance Co: BLUE CROSS OF CALIFORNIA

     ID Qualifier                Form   Care Type                 ID#

  No ID's found for provider and selected insurance co



          Enter ?? for more actions
AI   Add an ID                          DI   Delete an ID
EI   Edit an ID                         EX   Exit
Select Action: Quit// AI   Add an ID
Select Provider ID Qualifier: BLUE SHIELD ID
FORM TYPE APPLIED TO: 1500 FORMS ONLY
BILL CARE TYPE: b  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD ID
   FORM TYPE: 1500 FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT

Provider ID: 111XXX1B
```

The following screen will display.

```
Secondary Provider ID          May 11, 2005@11:17:20          Page:    1 of    1
          ** Lab or Facility Secondary IDs from Insurance Co **

Provider: IB Outside Facility (Non-VA Lab or Facility)
Insurance Co: BLUE CROSS OF CALIFORNIA

     ID Qualifier                Form   Care Type                 ID#
1    BLUE SHIELD ID              1500   INPT/OUTPT                111XXX1B



          Enter ?? for more actions
AI   Add an ID                          DI   Delete an ID
EI   Edit an ID                         EX   Exit
Select Action: Quit//
```

4.4.3 Define VA Laboratory or Facility Primary IDs/NPI

The Laboratory or Facility Primary ID for all VA divisions is the site's Federal Tax Number. This number will be automatically retrieved from the IB Site Parameters.

The VA Service Facility NPI and Taxonomy Code will not be entered or maintained by Billing personnel. Beginning with Patch IB*2.0*400, only those VA locations for which no NPI numbers were obtained, (i.e. MORC, CMOP) will populate the Service Facility. Because of this, there will usually be no VA Laboratory or Facility NPI in the 837 claim transmission.

4.4.4 Define VA Laboratory or Facility Secondary IDs

For each insurance company, users can define multiple Laboratory or Facility Secondary IDs for the VA by division and form type.

Step	Procedure
1	Access the option **Patient Insurance Menu ... →Insurance Company Entry/Edit**.
2	At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example.
3	From the **Insurance Company Editor** screen, enter the action, **ID Prov IDs/ID Parameters**.
4	From the **Billing Provider IDs** screen, enter the action **VA-Lab/Facility IDs**.
5	From the **VA-Lab/Facility IDs** screen, enter the action **Add an ID**.
6	At the **Division** prompt, accept the default for the main Division.
7	At the **ID Qualifier:** prompt, enter **Blue Shield** for this example.
8	At the **Form Type** prompt, enter **CMS-1500** for this example.
9	At the **VA Lab or Facility Secondary ID** prompt, enter the ID **1212XX1B** for this example.
10	Repeat these steps for the Form Type = **UB-04**, Qualifier = **Blue Cross** and ID = **1212XX1A**.
11	Repeat these steps for the Form Type = **UB-04**, Qualifier = **Commercial** and ID = **1313XXG2**.
	Note: Users may repeat these steps to define more Laboratory or Facility Secondary IDs. A maximum of 5 Laboratory or Facility Secondary IDs can be defined per division, form and insurance company.

```
VA-Lab/Facility IDs                May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

VA-Lab/Facility Primary ID: XX123456

VA-Lab/Facility Secondary IDs
   ID Qualifier              ID #             Form Type

No Laboratory or Facility IDs found




          Enter ?? for more actions
    Add an ID        Delete an ID
    Edit an ID       Exit

Select Action: Add an ID
```

The following screen will display.

```
VA-Lab/Facility IDs                May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

VA-Lab/Facility Primary ID: Federal Tax ID

VA-Lab/Facility Secondary IDs
     ID Qualifier                ID#              Form Type
Division: Name of Main Division/Default for All Divisions
1    Blue Cross                  1212XX1A         UB04
2    Blue Shield                 1212XX1B         1500

Division: CBOC
3    Commercial                  1313XXG2         UB04


          Enter ?? for more actions
    Add an ID        Delete an ID
    Edit an ID       Exit

Select Action: Edit//
```

4.5. Attending, Operating and Other Physicians and Rendering, Referring and Supervising Providers

A physician can appear on a UB-04 claim form as an Attending, Operating or Other Physician. A heath care provider (physician, nurse, physical therapist, etc.) can appear on a 1500 claim form as a Rendering, Referring or Supervising Provider.

All of these health care providers have a primary ID. Their primary ID is their Social Security Number (SSN). These physicians/providers can also have multiple secondary IDs that are either their own IDs or IDs provided by an insurance company.

The VA Physician's or Provider's NPI is stored in the New Person file. This file is not maintained by Billing personnel. The Non-VA Physician's or Provider's NPI is defined in Provider ID Maintenance.

Eventually, the NPI will become the provider's primary ID. It is transmitted in the 837 claim transmission and beginning with Patches IB*2.0*348 and 349, it will be printed on locally printed claim forms.

All of these types of health care providers can be either VA or non-VA employees.

4.5.1 Define a VA Physician/Provider's Primary ID/NPI

The VA Physician's or Provider's SSN and NPI are stored in the New Person file (#200). These IDs should be entered when the user is originally added to the system. The provider's Taxonomy code is entered along with the Person Class.

4.5.2 Define a VA Physician/Provider's Secondary IDs

Physicians and Providers can have both their own ID, such as a state medical license, or an ID provided by an insurance company.

4.5.2.1 Define a VA Physician/Provider's Own Secondary IDs

Physicians and other health care providers are assigned IDs that identify them. These IDs include a Social Security Number which serves as their primary ID. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- OB - State License Number
- EI – EIN
- SY - SSN (VA SSNs are defined in the New Person file)
- X5 – State Industrial Accident Provider Number
- 1G – UPIN Number

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **PO** for Provider Own IDs.
3	At the **(V)A or (N)on-VA provider: V//**: prompt, press **Return** to accept the default.
4	At the **Select V.A. PROVIDER NAME:** prompt, enter **IB,DOCTOR 1**.
	*This screen can be accessed through the **MCCR System Definition Menu.** Users must hold the **IB PROVIDER EDIT** security key to access this option.*

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

                Care Units
          CP  Care Units for Providers
          CB  Care Units for Billing Provider

                Non-VA Items
          NP  Non-VA Provider
          NF  Non-VA Facility

    Select Provider ID Maintenance Option: PO  Provider Own IDs

(V)A or (N)on-VA provider: V// A PROVIDER
Select V.A. PROVIDER NAME:IB,DOCTOR 1
```

Step	Procedure
6	At the **Select Action:** prompt, enter **AI** for Add an ID.
7	At the **Select ID Qualifier:** prompt, enter **State License** for this example.
8	At the **Select LICENSING STATE**: prompt, enter **California** for this example.
9	When asked if you are entering California as the 1st state for this provider, enter **Yes**.
10	At the **LICENSING STATE**: prompt, press **Return** to accept the default.
11	At the **LICENSING NUMBER**: prompt, enter **XXXXSTATE** for this example.

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider    : IB,DOCTORB (VA PROVIDER)

     ID Qualifier         Form     Care Type    Care Unit       ID#

  No ID's found for provider


          Enter ?? for more actions
AI   Add an ID                           DI   Delete an ID
EI   Edit an ID                          EX   Exit
Select Action: Quit// AI   Add an ID
Select ID Qualifier: ??

   Choose from:
   EIN        EI
   SOCIAL SECURITY NUMBER        SY
   STATE INDUSTRIAL ACCIDENT PROV        X5
   STATE LICENSE        0B
   UPIN        1G

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: 0B  State License
Select LICENSING STATE: CALIFORNIA
  Are you adding 'CALIFORNIA' as a new LICENSING STATE (the 1ST for this NEW PER
SON)? No// y  (Yes)
LICENSING STATE: CALIFORNIA//
LICENSE NUMBER: XXXXSTATE
```

The following screen will display.

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's Own IDs (No Specific Insurance Co) **
Provider    : IB,DOCTORB (VA PROVIDER)

     ID Qualifier         Form     Care Type    Care Unit       ID#
1    CA STATE LICENSE #                                        XXXXSTATE




          Enter ?? for more actions
AI   Add an ID                           DI   Delete an ID
EI   Edit an ID                          EX   Exit
Select Action: Quit//
```

4.5.2.2 Define a VA Physician/Provider's Insurance Company Secondary IDs

Physicians and other health care providers can be assigned secondary IDs by insurance companies. Some insurance companies assign one ID to be used by every physician/provider at a site. Other insurance companies assign each physician/provider his or her own ID. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- 1A - Blue Cross
- 1B - Blue Shield
- 1C - Medicare
- 1H - CHAMPUS
- G2 - Commercial
- LU - Location #
- N5 - Provider Plan Network
- 1G - UPIN

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **PI** for Provider Insurance IDs.
3	At the **(V)A or (N)on-VA provider: V//**: prompt, press **Return** to accept the default.
4	At the **Select V.A. PROVIDER NAME:** prompt, enter **IB,DOCTOR 1**.
5	At the **Select Insurance Co.**: prompt, enter **Blue Cross of California** for this example.

```
Provider ID Maintenance Main Menu

   Enter a code from the list.

              Provider IDs
         PO   Provider Own IDs
         PI   Provider Insurance IDs

              Insurance IDs
         BI   Batch ID Entry
         II   Insurance Co IDs

              Care Units
         CP   Care Units for Providers
         CB   Care Units for Billing Provider

              Non-VA Items
         NP   Non-VA Provider
         NF   Non-VA Facility

   Select Provider ID Maintenance Option: PI Provider Insurance IDs

 (V)A or (N)on-VA provider: V// A PROVIDER
Select V.A. PROVIDER NAME:IB,DOCTOR 1
Select INSURANCE CO: BLUE CROSS OF CALIFORNIA
```

Step	Procedure
6	At the **Select Action**: prompt, enter **AI** for Add an ID.
7	At the **Select ID Qualifier**: prompt, enter **1B – Blue Shield** for this example.
8	At the **FORM TYPE APPLIED TO**: prompt, enter **CMS-1500 Only** for this example.
9	At the **BILL CARE TYPE**: prompt, enter **0** for this example.
10	At the **CARE UNIT**: prompt, enter **Surgery** for this example.
11	At the **PROVIDER ID**: prompt, enter **XXXXBSHIELD** for this example.
	Defining an insurance company provided ID for a particular Care Unit is only necessary when the insurance company assigns physician/provider IDs by care unit.
	*Users can repeat these steps for this Physician/Provider adding more IDs from this insurance company or change insurance company or change physician/provider. Refer to **Section 3.7** to learn about copying IDs to multiple insurance companies.*
	*Note: If you do not define a **Network ID** for **TRICARE** claims, the system will automatically include the provider's **SSN** as the Network ID.*

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's IDs from Insurance Co **
Provider    : IB,DOCTORB (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

     ID Qualifier         Form     Care Type    Care Unit       ID#
  No ID's found for provider


          Enter ?? for more actions
AI   Add an ID                           DI   Delete an ID
EI   Edit an ID                          EX   Exit
Select Action: Quit// AI   Add an ID
Select ID Qualifier: ??
   Choose from:
   BLUE CROSS        1A
   BLUE SHIELD        1B
   CHAMPUS        1H
   COMMERCIAL        G2
   LOCATION NUMBER        LU
   MEDICARE PART A        1C
   MEDICARE PART B        1C
   PROVIDER PLAN NETWORK        N5
   UPIN        1G

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: Blue Shield
FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD ID
   FORM TYPE: CMS-1500 FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT
   CARE UNIT: Surgery

PROVIDER ID: XXXXBSHIELD
```

The following screen will display.

```
Physician/Provider ID                Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Physician/Provider's IDs from Insurance Co **
Provider    : IB,DOCTORB (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

     ID Qualifier          Form   Care Type    Care Unit       ID#
1    BLUE SHIELD ID        1500   INPT/OUTPT                   XXXXBSHIELD




          Enter ?? for more actions
AI   Add an ID                           DI   Delete an ID
EI   Edit an ID                          EX   Exit
Select Action: Quit//
```

4.5.3 Define non-VA Physician and Provider Primary IDs/NPI

Non-VA physicians and other health care providers are not VistA users so they are not normally in the New Person file unless they are also current/previous VA employees. Even if a physician/provider functions in both a VA and non-VA role, the SSN, NPI and Taxonomy Code of a non-VA Physician/Provider must be entered by Billing personnel using Provider ID Maintenance. Non-VA physician/provider primary and secondary legacy IDs are both defined the same way and the system knows to look for and use the SSN as the primary ID. Refer to the following **Section 3.4.4.1**.

*Note: Non-VA Physician/Provider IDs can be defined through Provider ID Maintenance through **PO > Provider Own IDS** or through **NP > Non- VA PROVIDER.***

4.5.3.1 Define a non-VA Physician/Provider's NPI

The NPI and Taxonomy Code for a non-VA Physician or Provider can be entered by Billing personnel using Provider ID Maintenance.

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **NP** for Non-VA Provider.
3	At the **Select a Non-VA Provider:** prompt, enter **IB,OUTSIDEPROV** for this example.
	*When accessing an existing entry, press **Return** to continue or, if necessary, the spelling of the provider's name can be corrected at the **NAME** prompt. Names should be entered in the following format: LAST NAME,FIRST NAME MIDDLE INITIAL.*
	*Note: Beginning with Patch IB*2*436, it will be possible to enter a provider into the VA New Person file as a VA provider and then enter that same provider in Provider Maintenance as a non-VA provider using the same name. It will no longer be necessary to manipulate the name by adding a middle initial (for example). It will also no longer be necessary to distinguish an individual provider from a facility by entering a comma in the provider's name.*
	*Users must hold the **IB PROVIDER EDIT** security key to access this option.*

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

                Care Units
          CP  Care Units for Providers
          CB  Care Units for Billing Provider

                Non-VA Items
          NP  Non-VA Provider
          NF  Non-VA Facility

    Select Provider ID Maintenance Option: NP Non-VA Provider
Select a NON-VA PROVIDER: IB,OUTSIDEPROV        INDIVIDUAL
For individual type entries: The name should be entered in
                             LAST,FIRST MIDDLE format.

Select a NON-VA PROVIDER: IB,OUTSIDEPROV INDIVIDUAL

If you do NOT want to edit the provider name or the provider type,
Then press return at the following NAME prompt.  Otherwise,
Retype the name as you want it entered into the system.
NAME: IB,OUTSIDEPROV //:
```

The following screen will display.

```
NON-VA PROVIDER INFORMATION   Dec 07, 2006@12:40:51          Page:    1 of    1

         Name: IB,OUTSIDEPROV
         Type: INDIVIDUAL PROVIDER
  Credentials: MD
    Specialty: 30
          NPI:
Taxonomy Code:

          Enter ?? for more actions
ED   Edit Demographics                  PI   Provider Ins ID
PO   Provider Own ID                    EX   Exit
Select Action: Quit// ED
```

Step	Procedure
4	At the **Select Action**: prompt, enter **ED** for Edit Demographics.
5	At the **Credentials**: prompt, press **Return** to accept the default.
6	At the **Specialty**: prompt, press **Return** to accept the default.
7	At the **NPI**: prompt, enter **0000000006** for this example.
8	At the **Taxonomy Code**: prompt, enter **15 Allopathic and Osteopathic**

Physicians 207RC0000X Internal Medicine Cardiovascular Disease for this example.

9 At the **Are you adding 'Allopathic and Osteopathic Physicians' as a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No//** prompt, enter **Yes** for this example.

10 At the **Primary Code**: prompt, enter **Yes** for this example.

11 At the **Status**: prompt, enter **Active** for this example.

A provider may have more than one Taxonomy Code.

```
NAME: IB,OUTSIDEPROV//
CREDENTIALS: MD//
SPECIALTY: 30//
NPI: 0000000006
Select TAXONOMY CODE: 15  Allopathic and Osteopathic Physicians     207RC0000X
                      Internal Medicine
                           Cardiovascular Disease
  Are you adding 'Allopathic and Osteopathic Physicians' as
    a new TAXONOMY CODE (the 1ST for this IB NON/OTHER VA BILLING PROVIDER)? No/
/ y  (Yes)
  PRIMARY CODE: Y  YES
  STATUS: A  ACTIVE
Select TAXONOMY CODE:
```

The following screen will display.

```
NON-VA PROVIDER INFORMATION   Dec 07, 2006@13:10:53          Page:    1 of    1


         Name: IB,OUTSIDEPROV
         Type: INDIVIDUAL PROVIDER
  Credentials: MD
    Specialty: 30
          NPI: 0000000006
Taxonomy Code: 207RC0000X (Primary)



          Enter ?? for more actions
ED   Edit Demographics                 PI   Provider Ins ID
PO   Provider Own ID                   EX   Exit
Select Action: Quit//
```

4.5.4 Define a non-VA Physician/Provider's Secondary IDs

4.5.4.1 Define a non-VA Physician/Provider's Own IDs

Non-VA Physicians and other health care providers are assigned IDs that identify them. These IDs include a Social Security Number which serves as a primary ID. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- OB - State License Number
- EI - EIN
- TJ – Federal Taxpayer's Number
- X5 – State Industrial Accident Provider Number

- 1G – UPIN
- SY - SSN

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **PO** for Provider Own IDs.
3	At the **(V)A or (N)on-VA provider: V*//***: prompt, enter **N** for Non-VA provider.
4	At the **Select Non V.A. PROVIDER NAME:** prompt, enter **IB,OUTSIDEDOC** for this example.
	*Note: For non-VA physicians and provider, be sure to define an SSN with the Qualifier SY as this will be used as the Attending, Operating, Other, Rendering, Referring or Supervising primary legacy ID.*

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

                Care Units
          CP  Care Units for Providers
          CB  Care Units for Billing Provider

                Non-VA Items
          NP  Non-VA Provider
          NF  Non-VA Facility

    Select Provider ID Maintenance Option: PO Provider Own IDs

(V)A or (N)on-VA provider: V//  n  NON-VA PROVIDER
Select Non V.A. PROVIDER NAME:IB,OUTSIDEDOC
```

Step	Procedure
5	At the Select Action**:** prompt, enter **AI** for Add an ID**.**
6	At the **Enter Provider ID Qualifier:** prompt, enter **Social Security Number** for this example.
7	At the **FORM TYPE APPLIED TO**: prompt, enter **0** for this example.
8	At the **BILL CARE TYPE**: prompt, enter **0** for this example.
9	At the **PROVIDER ID**: prompt, enter **XXXXX1212** for this example.
	Note: Users may repeat the above steps to enter additional IDs for a physician/provider.

```
Performing Provider ID              Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Performing Provider's Own IDs (No Specific Insurance Co) **
Provider    : IB,OUTSIDEDOC (NON-VA PROVIDER)

     ID Qualifier         Form     Care Type    Care Unit       ID#

  No ID's found for provider




          Enter ?? for more actions
AI   Add an ID                           DI   Delete an ID
EI   Edit an ID                          EX   Exit
Select Action: Quit// AI   Add an ID
Select ID Qualifier: ??

   Choose from:
   EIN        EI
   SOCIAL SECURITY NUMBER        SY
   STATE INDUSTRIAL ACCIDENT PROV        X5
   STATE LICENSE        0B
   UPIN        1G

Enter the Qualifier that identifies the type of ID.

Select ID Qualifier: SY Social Security Number
FORM TYPE APPLIED TO: 0  BOTH UB-04 AND CMS-1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: ALL INSURANCE
   PROV TYPE: SOCIAL SECURITY NUMBER
   FORM TYPE: BOTH UB-04 & CMS-1500 FORMS
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: XXXXX1212
```

The following screen will display.

```
Performing Provider ID              Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Performing Provider's Own IDs (No Specific Insurance Co) **
Provider    : IB,OUTSIDEDOC (NON-VA PROVIDER)

     ID Qualifier         Form     Care Type    Care Unit       ID#
1    SOCIAL SECURITY NUMB  BOTH    INPT/OUTPT                   XXXXX1212




          Enter ?? for more actions
AI   Add an ID                           DI   Delete an ID
EI   Edit an ID                          EX   Exit
Select Action: Quit//
```

4.5.4.2 Define a non-VA Physician/Provider's Insurance Company Secondary IDs

Physicians and other health care providers are assigned secondary IDs by insurance companies. In addition to their SSN, they may also have one or more of the following types of secondary IDs:

- 1A - Blue Cross
- 1B - Blue Shield
- 1C - Medicare
- 1G - UPIN
- 1H - CHAMPUS
- G2 - Commercial
- LU - Location #
- N5 - Provider Plan Network

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **NP** for Non-VA Provider.
3	At the **Select a NON-VA PROVIDER:** prompt, enter **IB,OUTSIDEDOC**.

```
Provider ID Maintenance Main Menu

   Enter a code from the list.

              Provider IDs
         PO   Provider Own IDs
         PI   Provider Insurance IDs

              Insurance IDs
         BI   Batch ID Entry
         II   Insurance Co IDs

              Care Units
         CP   Care Units for Providers
         CB   Care Units for Billing Provider

              Non-VA Items
         NP   Non-VA Provider
         NF   Non-VA Facility

   Select Provider ID Maintenance Option: NP Non-VA Provider

(V)A or (N)on-VA provider: V// N Non-VA PROVIDER
Select a NON-VA PROVIDER: IB,OUTSIDEDOC
Select INSURANCE CO: BLUE CROSS OF CALIFORNIA
```

Step	Procedure
4	At the **Select Action**: prompt, enter **PI** for Provider Ins ID.
5	At the **Select INSURANCE CO:** prompt, enter **Blue Cross of California** for this example.
6	At the **Select Action**: prompt, enter **AI** for Add an ID**.**

6 At the **Select ID Qualifier**: prompt, enter **1B – Blue Shield** for this example.
7 At the **FORM TYPE APPLIED TO**: prompt, enter **CMS-1500 Only** for this example.
8 At the **BILL CARE TYPE**: prompt, enter **0** for this example.
9 At the **PROVIDER ID**: prompt, enter **XXBSHIELD** for this example.

Users can repeat these steps for this Physician/Provider adding more IDs from this insurance company or change insurance company or change physician/provider.

```
Performing Provider ID              Nov 02, 2005@10:24:46          Page:    1 of    1
             ** Performing Provider's IDs from Insurance Co **
Provider    : IB,OUTSIDEDOC (Non-VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

     ID Qualifier         Form     Care Type    Care Unit       ID#

  No ID's found for this insurance co.



          Enter ?? for more actions
AI   Add an ID                          DI   Delete an ID
EI   Edit an ID                         EX   Exit
Select Action: Quit// AI   Add an ID
Select ID Qualifier: ??

   Choose from:
   BLUE CROSS        1A
   BLUE SHIELD        1B
   CHAMPUS        1H
   COMMERCIAL        G2
   LOCATION NUMBER        LU
   MEDICARE PART A        1C
   MEDICARE PART B        1C
   PROVIDER PLAN NETWORK        N5
   UPIN        1G

Enter the Qualifier that identifies the type of ID.

Select Provider ID Type: Blue Shield
FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD ID
   FORM TYPE: CMS-1500 FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT
PROVIDER ID: XXBSHIELD
```

The following screen will display.

```
Performing Provider ID              Nov 02, 2005@10:24:46          Page:    1 of    1
              ** Performing Provider's IDs from Insurance Co **
Provider    : IB,OUTSIDEDOC (Non-VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA (Parent)

     ID Qualifier           Form   Care Type    Care Unit       ID#
1    BLUE SHIELD ID         1500   INPT/OUTPT                   XXXXBSHIELD




          Enter ?? for more actions
AI   Add an ID                          DI   Delete an ID
EI   Edit an ID                         EX   Exit
Select Action: Quit//
```

4.5.5 Define Insurance Company IDs

Both individual Physician/Provider secondary IDs and insurance company default Physician/Provider secondary IDs provided by an insurance company can be entered and copied from within Insurance Company IDs.

There are 3 options:

- I – Individual IDs
- A – Individual and Default IDs
- D – Default IDs

Option A is the basically the same as I and D combined so users can add Physician/Provider secondary IDs and/or default secondary IDs.

4.5.5.1 Define Default Physician/Provider Insurance Company Secondary IDs

Users can use the Provider ID Maintenance option, Insurance Company IDs, to enter numbers that are assigned by an insurance company to be used as default Attending, Operating, Other, Rendering, Referring and Supervising Secondary IDs for all physicians and health care providers. These IDs with be automatically sent with all 837 claims to the insurance company for which the default IDs are defined.

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **II** for Insurance Co IDs.
3	At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example.
4	At the **Select Display Content**: prompt, enter **D**.

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

                Care Units
          CP  Care Units for Providers
          CB  Care Units for Billing Provider

                Non-VA Items
          NP  Non-VA Provider
          NF  Non-VA Facility

    Select Provider ID Maintenance Option: II  Insurance Co IDs
Select INSURANCE COMPANY NAME:  BLUE CROSS OF CALIFORNIA     PO BOX 60007          LOS
ANGELES     CALIFORNIA        Y
SELECT DISPLAY CONTENT: A//D  INSURANCE CO DEFAULT IDS
```

Step	Procedure
5	At the **Select Action**: prompt, enter **AI** for Add an ID.

```
INSURANCE CO PROVIDER ID      Dec 19, 2005@12:24:41          Page:    1 of    2
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
     PROVIDER NAME         FORM   CARE TYPE    CARE UNIT       ID#


Provider ID Type: BLUE SHIELD
1    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    BSDEFAULT

Provider ID Type: COMMERCIAL
2    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    COMDEFAULT

Provider ID Type: PROVIDER PLAN NETWORK
3    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    NETDEFAULT

Provider ID Type: UPIN
4    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    UPINDEFAULT

+         Enter ?? for more actions
AI   Add an ID            DP   Display Ins Params   VI   View IDs by Type
DI   Delete an ID         CI   Change Ins Co        CU   Care Unit Maint
EI   Edit an ID           CD   Change Display       EX   Exit
Select Action: Next Screen//AI   Add an ID
```

Step	Procedure
6	At the **Select Provider (optional):** prompt, press **Return** to leave the prompt blank.
7	At the **YOU ARE ADDING A PROVIDER ID THAT WILL BE THE INSURANCE CO DEFAULT IS THIS OK?:** prompt, enter **YES**.
8	At the **Select Provider ID Type:** prompt, enter **Blue Cross** for this example.

9 At the **FORM TYPE APPLIED TO:** prompt, enter **UB-04 Forms Only** for this example.
10 At the **BILL CARE TYPE:** prompt, enter **0** for BOTH INPATIENT AND OUTPATIENT for this example.
11 At the **PROVIDER ID:** prompt, enter **BCDEFAULT** for this example.

```
YOU ARE ADDING A PROVIDER ID THAT WILL BE THE INSURANCE CO DEFAULT


Select Provider ID Type: BLUE CROSS     1A

FORM TYPE APPLIED TO: UB-04// UB-04 FORMS ONLY
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE CROSS
   FORM TYPE: UB-04 FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: BCDEFAULT
```

The following screen will display.

```
INSURANCE CO PROVIDER ID      Dec 19, 2005@12:34:01          Page:    1 of    2
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
PROVIDER NAME          FORM   CARE TYPE    CARE UNIT       ID#

Provider ID Type: BLUE CROSS
1    <<INS CO DEFAULT>>    UB-04  INPT/OUTPT                    BCDEFAULT

Provider ID Type: BLUE SHIELD
2    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    DEFALLProv

Provider ID Type: COMMERCIAL
3    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    COMDEFAULT

Provider ID Type: PROVIDER PLAN NETWORK
4    <<INS CO DEFAULT>>    BOTH   INPT/OUTPT                    NETDEFAULT

+         Enter ?? for more actions
AI   Add an ID            DP   Display Ins Params   VI   View IDs by Type
DI   Delete an ID         CI   Change Ins Co        CU   Care Unit Maint
EI   Edit an ID           CD   Change Display       EX   Exit
Select Action: Next Screen//
```

Note: This default ID will be transmitted on all claims where Blue Cross of California is the payer as a Physician/Provider secondary ID.

4.5.5.2 Define Individual Physician/Provider Insurance Company Secondary IDs

Users can use the Provider ID Maintenance option, Insurance Company IDs, to enter numbers that are assigned by an insurance company as individual Attending, Operating, Other, Rendering, Referring and Supervising Secondary IDs.

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **II** for Insurance Co IDs.
3	At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example.

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

                Care Units
          CP  Care Units for Providers
          CB  Care Units for Billing Provider

                Non-VA Items
          NP  Non-VA Provider
          NF  Non-VA Facility

    Select Provider ID Maintenance Option: ii  Insurance Co IDs

Select INSURANCE COMPANY NAME:    BLUE CROSS OF CALIFORNIA      PO BOX 60007          LOS
ANGELES     CALIFORNIA       Y
```

Step	Procedure
4	At the **Select Display Content**: prompt, enter **I** for this example.
5	At the **Do you want to display IDs for a Specific Provider**: prompt, enter **No** for this example.

```
SELECT DISPLAY CONTENT: A// ??

(D) DISPLAY CONTAINS ONLY THOSE IDS ASSIGNED AS DEFAULTS TO THE FACILITY BY
    THE INSURANCE COMPANY
(I) DISPLAY CONTAINS ONLY THOSE IDS ASSIGNED TO INDIVIDUAL PROVIDERS BY THE
    INSURANCE COMPANY
(A) DISPLAY CONTAINS ALL IDS ASSIGNED BY THE INSURANCE COMPANY FOR ONE OR ALL PROVIDER
ID TYPES

     Select one of the following:

          D         INSURANCE CO DEFAULT IDS
          I         INDIVIDUAL PROVIDER IDS FURNISHED BY THE INS CO
          A         ALL IDS FURNISHED BY THE INS CO BY PROVIDER TYPE

SELECT DISPLAY CONTENT: A// I  INDIVIDUAL PROVIDER IDS FURNISHED BY THE INS CO
DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER?: NO//
```

Step	Procedure
6	At the **Select Action**: prompt, enter **AI** for Add an ID.

```
INSURANCE CO PROVIDER ID      Dec 15, 2005@15:36:31          Page:    1 of   89
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
  PERFORMING PROV ID MAY REQUIRE CARE UNIT

     PROVIDER ID TYPE      FORM   CARE TYPE    CARE UNIT       ID#

Provider: IB,DOCTOR3
1    PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   MDXXXXXA

Provider: IB,DOCTOR9
2    PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   GXXXXXA

Provider: IB,DOCTOR10
3    PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   GXXXXXX

Provider: IB,DOCTOR76
4    PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   GXXXXXX

+         Enter ?? for more actions
AI   Add an ID            DP   Display Ins Params   VI   View IDs by Type
DI   Delete an ID         CI   Change Ins Co        CU   Care Unit Maint
EI   Edit an ID           CD   Change Display       EX   Exit
Select Action: Next Screen// AI   Add an ID
```

Step	Procedure
7	At the **Select ID Qualifier**: prompt, enter **1B – Blue Shield** for this example.
8	At the **FORM TYPE APPLIED TO**: prompt, enter **CMS-1500 Only** for this example.
9	At the **BILL CARE TYPE**: prompt, enter **0** for this example.
10	At the **CARE UNIT**: prompt, enter **Surgery** for this example.
11	At the **PROVIDER ID**: prompt, enter **BSXXXXX** for this example.

```
Select PROVIDER: IB,DOCTOR7

Select Provider ID Type:  BLUE SHIELD     1B

FORM TYPE APPLIED TO: CMS-1500 FORMS ONLY
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD
   FORM TYPE: CMS-1500 FORM ONLY
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT
   CARE UNIT: Surgery

PROVIDER ID: BSXXXXX
```

The following screen will display.

```
INSURANCE CO PROVIDER ID      Dec 15, 2005@16:11:31          Page:   49 of   89
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
  PERFORMING PROV ID MAY REQUIRE CARE UNIT

     PROVIDER ID TYPE      FORM   CARE TYPE    CARE UNIT       ID#
+

Provider: IB,DOCTOR15
194  PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   GXXXXX

Provider: IB,DOCTOR54
195  PROVIDER PLAN NETWOR  BOTH   INPT/OUTPT                   G4XXXXX

Provider: IB,DOCTOR7
196  BLUE CROSS            UB-04  INPT/OUTPT                   BCXXXXXX2
197  BLUE SHIELD           1500   INPT/OUTPT    Surgery        BSXXXXX

Provider: IB,DOCTOR6
+         Enter ?? for more actions
AI   Add an ID            DP   Display Ins Params   VI   View IDs by Type
DI   Delete an ID         CI   Change Ins Co        CU   Care Unit Maint
EI   Edit an ID           CD   Change Display       EX   Exit
Select Action: Next Screen//
```

4.5.6 Define either a Default or Individual Physician/Provider Secondary ID

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **II** for Insurance Co IDs.
3	At the **Select Insurance Company Name**: prompt, enter **Blue Cross of California** for this example (the Parent company).
4	At the **Select Display Content**: prompt, enter **A** for this example.
5	At the **DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER ID TYPE?: NO//** prompt, accept the default.

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

                Care Units
          CP  Care Units for Providers
          CB  Care Units for Billing Provider

                Non-VA Items
          NP  Non-VA Provider
          NF  Non-VA Facility

    Select Provider ID Maintenance Option: II  Insurance Co IDs

Select INSURANCE COMPANY NAME:     BLUE CROSS OF CALIFORNIA      PO BOX 60007
     LOS ANGELES      CALIFORNIA        Y

SELECT DISPLAY CONTENT: A// LL IDS FURNISHED BY THE INS CO BY PROVIDER TYPE

DO YOU WANT TO DISPLAY IDS FOR A SPECIFIC PROVIDER ID TYPE?: NO//
```

Step	Procedure
6	At the **Select Action**: prompt, enter **AI** for Add an ID.

```
INSURANCE CO PROVIDER ID      Dec 15, 2005@16:18:07          Page:    1 of   31
Insurance Co: BLUE CROSS OF CALIFORNIA (Parent)
  PERFORMING PROV ID MAY REQUIRE CARE UNIT

     PROVIDER NAME          FORM    CARE TYPE     CARE UNIT       ID#

Provider ID Type: BLUE CROSS
1    IB,DOCTOR7             UB-04   INPT/OUTPT                    BCXXXXX

Provider ID Type: BLUE SHIELD
2    <<INS CO DEFAULT>>     BOTH    INPT/OUTPT                    DEFALLProv
3    IB Outside Facility    BOTH    INPT/OUTPT                    BSFACXXXX
4    IB,DOCTOR8             BOTH    INPT/OUTPT                    BSINDOUT
5    IB,DOCTOR33            BOTH    INPT/OUTPT                    BSLIM
6    IB,DOCTOR7             1500    INPT/OUTPT                    BSXXXXX

Provider ID Type: PROVIDER PLAN NETWORK
7    IB,DOCTOR64            BOTH    INPT/OUTPT                    MD22356A
+         Enter ?? for more actions
AI   Add an ID              DP   Display Ins Params    VI   View IDs by Type
DI   Delete an ID           CI   Change Ins Co         CU   Care Unit Maint
EI   Edit an ID             CD   Change Display        EX   Exit
Select Action: Next Screen//AI Add an ID
```

Step	Procedure

At the Select Provider (optional) prompt, enter a Provider's Name to enter an individual ID or leave it blank to enter a default ID and then continue to define the ID as before.

```
Select PROVIDER (optional): IB,DOCTOR7

     Searching for a VA PROVIDER
  IB,DOCTOR7      1XXXX      LZZ      114      RESIDENT PHYSICIAN
        ...OK? Yes//    (Yes)


Select Provider ID Type: COMMERCIAL        G2

FORM TYPE APPLIED TO: 0  BOTH UB-04 AND CMS-1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: COMMERCIAL
   FORM TYPE: BOTH UB-04 & CMS-1500 FORMS
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT

PROVIDER ID: CMXXXXXX
```

4.6. Care Units

Some insurance companies assign the same IDs to multiple Physician/Providers, based upon Care Units, to be used as *Physician/Provider Secondary IDs* on claims. This allows more than one person to have the same ID without everyone having the same ID.

Example: Insurance Company A assigns the number XXXXXX1 to a care unit called Care Unit A and assigns this number and care unit to Dr. A, Dr. B, Dr. C and Dr. E. as their Physician/Provider Secondary ID. The same insurance company assigns the number XXXXXX2 to a care unit called Care Unit B and assigns this number and care unit to Dr. F, Dr. G, Dr. H and Dr. I. as their Physician/Provider Secondary IDs.

Some insurance companies assign IDs to be used as *Billing Provider Secondary IDs* on claims for services performed for specific types of care.

Example: Insurance Company A assigns the number XXXXHH to be used as the Billing Provider Secondary ID (Billing Screen 3) when Home Health services are provided. The same insurance company assigns the number XXXXER as the Billing Provider Secondary ID (Billing Screen 3) when Emergency services are provided.

The names of the "care unit" used by insurance companies are specified by the insurance companies and do not relate directly to the medical services or departments of the medical center. For this reason, users must define these Care Units in Provider ID Maintenance.

4.6.1 Define Care Units for Physician/Provider Secondary IDs

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **CP** for Care Units for Providers.
3	At the **Select INSURANCE CO**: prompt, enter **Blue Cross of California** for this example.

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

                Care Units
          CP  Care Units for Providers
          CB  Care Units for Billing Provider

                Non-VA Items
          NP  Non-VA Provider
          NF  Non-VA Facility

    Select Provider ID Maintenance Option: CP  Care Units for Providers

Select INSURANCE CO:  Blue Cross of California
```

Step	Procedure
4	At the **Select Action**: prompt, enter **AU** for Add a Unit.
5	At the **SELECT CARE UNIT FOR THE INSURANCE CO**: prompt, enter Surgery for this example. Confirm Surgery.
6	At the **IB PROVIDER ID CARE UNIT DESCRIPTION**: prompt, enter a free text description of the Care Unit.
7	At the **ID Qualifier**: prompt, enter **Blue Shield** for this example.
8	At the **FORM TYPE APPLIED TO**: prompt, enter **0** for **BOTH UB-04 & CMS-1500 FORMS**.
9	At the **BILL CARE TYPE**: prompt, enter **0** for **BOTH INPATIENT AND OUTPATIENT**.

Remember, 'Blue Cross' ID can only be used on Institutional claims.

```
PROVIDER ID CARE UNITS        Nov 03, 2005@11:56:45          Page:    1 of    1

Insurance Co: BLUE CROSS OF CALIFORNIA

    CARE UNIT NAME                  DESCRIPTION
No CARE UNITs Found for Insurance Co


          Enter ?? for more actions
AU   Add a Unit                          DU   Delete a Unit
EU   Edit a Unit                          EX   Exit
Select Action: Quit// AU   Add a Unit
SELECT CARE UNIT FOR THE INSURANCE CO: Surgery
  Are you adding 'Surgery' as a new IB PROVIDER ID CARE UNIT? No// y  (Yes)
   IB PROVIDER ID CARE UNIT DESCRIPTION: Ambulatory Surgery

ID TYPE: BLUE SHIELD
FORM TYPE APPLIED TO: 0  BOTH UB-04 & CMS-1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
CARE UNIT: Surgery

  >> CARE UNIT COMBINATION FILED FOR THE INSURANCE CO
PRESS ENTER TO CONTINUE
```

The following screen will display.

```
PROVIDER ID CARE UNITS        Nov 03, 2005@11:56:45          Page:    1 of    1

Insurance Co: BLUE CROSS OF CALIFORNIA

    CARE UNIT NAME                  DESCRIPTION
1   Surgery                         Ambulatory Surgery
                             o BLUE SHIELD ID       Both form types  Inpt/Outpt




          Enter ?? for more actions
AU   Add a Unit                          DU   Delete a Unit
EU   Edit a Unit                          EX   Exit
Select Action: Quit//
```

Once you have defined a Care Unit, when you go to define physician/provider's IDs furnished by an insurance company, you will be prompted to enter the name of the Care Unit if you enter the same ID Qualifier, Form Type and Bill Care Type as those for which you previously defined a Care Unit.

```
PROVIDER ID                    Nov 21, 2005@09:52:39          Page:    1 of    1
                  ** Provider IDs Furnished by Insurance Co **
PROVIDER    : IB,DOCTOR7 (VA PROVIDER)
INSURANCE CO: BLUE CROSS OF CALIFORNIA
     PROVIDER ID TYPE      FORM   CARE TYPE    CARE UNIT       ID #

  No ID's found for provider and selected insurance co




          Enter ?? for more actions
AU   Add a Unit                          DU   Delete a Unit
EU   Edit a Unit                         EX   Exit
Select Action: Quit// AU   Add a Unit
CHOOSE 1-2: 2  BLUE SHIELD ID
FORM TYPE APPLIED TO: 0  BOTH UB-04 AND CMS-1500 FORMS
BILL CARE TYPE: 0  BOTH INPATIENT AND OUTPATIENT
Select IB PROVIDER ID CARE UNIT: Surgery       Ambulatory Surgery     BLUE CROSS
 OF CALIFORNIA

THE FOLLOWING WAS CHOSEN:
   INSURANCE: BLUE CROSS OF CALIFORNIA
   PROV TYPE: BLUE SHIELD ID
   FORM TYPE: BOTH UB-04 & CMS-1500 FORMS
   CARE TYPE: BOTH INPATIENT AND OUTPATIENT
   CARE UNIT: Surgery

PROVIDER ID: XXXXBS
```

When creating a bill for a patient with this payer, if IB,Doctor7 is entered on Screen 8, this ID for the Care Unit, Surgery, will be one of the Physician/Provider's Secondary IDs available.

```
                  **** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS OF CALIFORNIA
PROVIDER: IB,DOCTOR7 (RENDERING)


SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

  1    -  NO SECONDARY ID NEEDED
  2    -  ADD AN ID FOR THIS CLAIM ONLY
  3    -  XXXXBS                        BLUE SHIELD ID   Surgery

Selection: 1//
```

4.6.2 Define Care Units for Billing Provider Secondary IDs

Step	Procedure
1	Access the option **MCCR SYSTEM DEFINITION MENU→Provider ID Maintenance**.
2	At the **Select Provider ID Maintenance Option:** prompt, enter **CB** for Care Units for Billing Provider.

3 At the **Select INSURANCE CO**: prompt, enter **Blue Cross of California** for this example.

```
Provider ID Maintenance Main Menu

    Enter a code from the list.

                Provider IDs
          PO  Provider Own IDs
          PI  Provider Insurance IDs

                Insurance IDs
          BI  Batch ID Entry
          II  Insurance Co IDs

                Care Units
          CP  Care Units for Providers
          CB  Care Units for Billing Provider

                Non-VA Items
          NP  Non-VA Provider
          NF  Non-VA Facility

    Select Provider ID Maintenance Option: CB  Care Units for Billing Provider

Select INSURANCE CO: Blue Cross of California
```

Step	Procedure
6	At the **Select Action**: prompt, enter **AU** for Add a Unit.
7	At the **Enter the Division for this Care Unit:** prompt, press **Return** to accept the default.
8	At the **Enter Care Unit Name**: prompt, enter **Anesthesia** for this example.
9	At the **Enter a Care Unit Description**: prompt, enter a free text description.

Users may repeat these steps to create multiple Care Units for multiple divisions.

*Refer to **Section 3.1.2.3** to learn how to assign Billing Provider Secondary IDs to Care Units.*

```
Care Units - Billing Provider  May 27, 2005@11:17:46          Page:    1 of    0

Insurance Co: BLUE CROSS OF CALIFORNIA

Care Unit Name             Division              Description
No Care Units defined for this Insurance Co.

          Enter ?? for more actions
AU   Add a Unit                          DU   Delete a Unit
EU   Edit a Unit                         EX   Exit
Select Action: Quit// AU   Add a Unit
Enter the Division for this Care Unit: Main Division//
Enter Care Unit name: Anesthesia
  Are you adding 'Anesthesia' as
    a new Care Unit for Main Division? No// y  (Yes)
Enter a Care Unit Description: Free Text Description

Care Unit combination filed for this Insurance Co.
```

The following screen will display.

```
Care Units - Billing Provider May 27, 2005@11:17:46          Page:    1 of    0

Insurance Co: BLUE CROSS/BLUE SHIELD

  Care Unit Name                    Description
-------------------------------------------------------------------------------
Division: Main Division
  Anesthesia                        Free Text Description
  Reference Lab                     Free Text Description
  Home Health                       Free Text Description

Division: Remote Clinic
  Reference Lab                     Free Text Description


          Enter ?? for more actions
AU   Add a Unit                          DU   Delete a Unit
EU   Edit a Unit                         EX   Exit
Select Action: Quit//    QUIT
```

4.7. ID Parameters by Insurance Company

In addition to defining Care Units and Physician/Provider IDs in Provider ID Maintenance, there are also ID parameters that can be set for an insurance company that effect which IDs get sent on 837 claims transmissions to an insurance company.

Users need to be aware of these parameters so they can be set *if needed*. They do not need to be set unless there is a specific need for a particular insurance company.

Step	Procedure
1	Access the option **Insurance Company Entry/Edit**.
2	At the **Select INSURANCE COMPANY NAME**: prompt, enter **BLUE CROSS OF CALIFORNIA** for this example.
3	From the **Insurance Company Editor,** enter the **Prov IDs/ID Param** action.

```
Insurance Company Editor      Oct 01, 2007@14:27:13          Page:    1 of    9
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: HEALTH INSURANCE                    Currently Active

                           Billing Parameters
  Signature Required?: NO                      Filing Time Frame:
           Reimburse?: WILL REIMBURSE           Type Of Coverage: HEALTH INSURAN
    Mult. Bedsections:                             Billing Phone: 800/933-9146
     Diff. Rev. Codes:                        Verification Phone: 800/933-9146
       One Opt. Visit: NO                     Precert Comp. Name:
  Amb. Sur. Rev. Code:                             Precert Phone: 800/274-7767
  Rx Refill Rev. Code:


                              EDI Parameters
               Transmit?: YES-LIVE                Insurance Type: HMO
+          Enter ?? for more actions                                        >>>
BP  Billing/EDI Param     IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Action: Next Screen// ID  Prov IDs/ID Param
```

Step	Procedure
4	From the **Billing Provider IDs** screen, enter the **ID Parameters** action.

```
Billing Provider IDs (Parent) May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co: BLUE CROSS OF CALIFORNIA    Billing Provider Secondary IDs
     ID Qualifier                ID #             Form Type
Division: Name of Main Division/Default for All Divisions
1    Electronic Plan Type        XXXXXXXXX        UB-04
2    Electronic Plan Type        XXXXXXXX1X       1500




          Enter ?? for more actions
    Add an ID            Additional IDs              Exit
    Edit an ID           ID Parameters
    Delete an ID         VA-Lab/Facility IDs

Select Action: Edit// ID Parameters
```

Step	Procedure
4	From the **Billing Provider IDs** screen, enter the **ID Parameters** action.
	The ID Parameter Maint. Screen displays the current parameter values.
5	At the **Select Action**: prompt, enter the **Edit Params** action.

```
ID Parameter Maint.          May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Attending/Rendering Provider Secondary ID
Default ID (1500): BLUE SHIELD
Default ID (UB): BLUE CROSS
Require ID on Claim: BOTH UB-04 AND CMS-1500 REQUIRED

Referring Provider Secondary ID
Referring Provider Secondary ID
Default ID (1500): BLUE SHIELD
Require ID on Claim: CMS-1500

Billing Provider Secondary IDs
Use Attending/Rendering ID as Billing Provider Sec. ID?: NO
Transmit no Billing Provider Sec ID for the following Electronic Plan Types:

Billing Provider/Service Facility
+          Enter ?? for more actions
    Edit Params      Edit Billing Prov Params       Exit

Select Action: Next Screen// Edit Params
```

The following will display.

```
Attending/Rendering Provider Secondary ID
Default ID (1500): BLUE SHIELD//
Default ID (UB): BLUE CROSS//
Require ID on Claim: BOTH UB-04 AND CMS-1500 REQUIRED
         //

Referring Provider Secondary ID
Default ID (1500): BLUE SHIELD//
Require ID on Claim: CMS-1500//

Billing Provider Secondary IDs
Use Att/Rend ID as Billing Provider Sec. ID (1500)?: NO
         //
Use Att/Rend ID as Billing Provider Sec. ID (UB)?: NO
         //

Billing Provider/Service Facility
Always use main VAMC as Billing Provider (1500)?: NO
         //
Always use main VAMC as Billing Provider (UB-04)?: NO
         //
```

4.7.1 Define Attending/Rendering Provider Secondary ID Parameters

Users can define the type of ID that will be the default secondary ID for the Rendering Provider or Attending Physician during the creation of a claim.

A type of default secondary ID can be defined for a CMS-1500 claim and/or a UB-04 claim.

Users can also set a parameter which will make these IDs required on a claim. If they are required and the physician/provider on the claim does not have a secondary ID of the type required, the claim can not be authorized.

```
Attending/Rendering Provider Secondary ID
Default ID (1500): BLUE SHIELD ID
Default ID (UB04): BLUE CROSS ID
Require ID on Claim: BOTH
```

4.7.2 Define Referring Provider Secondary ID Parameters

Users can define the type of ID that will be the default secondary ID for the Referring Provider during the creation of a CMS-1500 claim.

A type of default secondary ID can be defined for a CMS-1500 claim.

Users can also set a parameter which will make this ID required on a claim. If it is required and the referring provider on the claim does not have a secondary ID of the type required, the claim can not be authorized.

The default type of ID for a Referring Provider is a UPIN but users may override this default.

```
Referring Provider Secondary ID
Default ID (1500): UPIN// BLUE SHIELD ID
Require ID on Claim: CMS-1500 REQUIRED
```

4.7.3 Define Billing Provider Secondary ID Parameters

If an insurance company wants the Billing Provider Secondary ID (Billing Screen 3) to be the same as the Attending Physician's or the Rendering Provider's ID, users can set the Send Attending/Rendering ID as Billing Provider Sec. ID?: parameter to Yes. The default value is No.

```
Billing Provider Secondary IDs
Send Attending/Rendering ID as Billing Provider Sec. ID?: No// Yes
```

If the payer requires the Attending/Rendering Physician/Provider's Secondary ID as the Billing Provider Secondary ID, this parameter can be set and a default Attending/Rendering ID type can be set and then users can just accept the default ID on Billing Screen 8 and it will be transmitted as the Physician/Provider's Secondary ID and the Billing Provider Secondary ID.

4.7.4 Define Billing Provider/Service Facility Parameters

For those payers who are unable to accept claims where the Billing Provider is the lowest enumerated entity such as a CBOC or Pharmacy, users can set one of the following parameters, by payer and form type, which will force the Billing Provider to always be the main division in the database (VAMC).

```
Billing Provider/Service Facility
Always use main VAMC as Billing Provider (1500)?: NO// YES
Always use main VAMC as Billing Provider (UB-04)?: NO
```

Once one or both of these parameters has been set to YES, then the following parameters will become available.

```
Send VA Lab/Facility IDs or Facility Data for VAMC?: YES//
Use the Billing Provider (VAMC) Name and Street Address?: NO//
```

When set to NO, first parameter will suppress the transmission of the Service Facility loop data when the service is provided at the VAMC. When set to YES, the second parameter will cause the VAMC's street address from the Institution file to be transmitted as the Billing Provider's address instead of the Pay-to Provider's address.

*This group of parameters was designed to allow a site to return, as much as possible , to a pre-Patch IB*2*400 state where the Billing Provider was always the VAMC and the Service Facility was where the care was provided.*

4.7.5 Define VA Service Facility Parameters

This parameter was changed with Patch IB*2*400. The parameter will only exist as part of the Billing Provider/Service Facility parameters in Section 4.7.4. The VA Billing Provider information will no longer be repeated in the Service Facility loops for non-Fee Basis claims. The Service Facility will be blank for *most* VA claims.

```
VA-Laboratory or Facility IDs
Send VA Lab/Facility IDs or Facility Data?: No//
```

4.7.6 Define No Billing Provider Secondary IDs by Plan Type

Some insurance companies do not want any Billing Provider Secondary IDs to be transmitted in the 837 claim transmission for claims to specific plan types.

To define which plan types require no Billing Provider Secondary IDs, users must enter the plan types.

Step	Procedure
1	From the **ID Parameter Maint.** screen, enter the **Edit Billing Prov Params** action.
	The first Billing Provider Secondary ID will still be sent with the claim regardless of this parameter. The first ID is a calculated value used by the clearinghouse for sorting purposes.
2	At the **Select Action**: prompt, enter **Add Plan**.
3	At the **Enter Electronic Plan Type**: prompt, enter **PPO** for this example.

```
Billing Provider Parameters   May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Transmit No Billing Provider Sec ID for the following Electronic Plan Types:
```

```
 1 HMO



          Enter ?? for more actions
    Add Plan      Delete Plan       Exit

Select Action: Add Plan
Enter Electronic Plan Type: PPO
```

The following screen will display.

```
Billing Provider Parameters   May 27, 2005@12:48:29          Page:    1 of    1
Insurance Co.: BLUE CROSS OF CALIFORNIA

Transmit No Billing Provider Sec ID for the following Electronic Plan Types:
 1 HMO
 2 PPO

          Enter ?? for more actions
    Add Plan      Delete Plan       Exit

Select Action: Add Plan
```

4.7.7 View Associated Insurance Companies, Provider IDs, and ID Parameters

When in the Insurance Company Editor, users can scroll through the information that has been defined for a particular insurance company.

Patch IB*2.0*320 added sections to display: Associated Insurance Companies; Provider IDs and ID Parameters.

```
Insurance Company Editor      Nov 22, 2005@10:26:11          Page:    5 of    7
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: BLUE CROSS                    Currently Active
+
          Associated Insurance Companies
  This insurance company is defined as a Parent Insurance Company.
  There are 4 Child Insurance Companies associated with it.
  Select the "AC  Associate Companies" action to enter/edit the children.

                  Provider IDs
Billing Provider Secondary ID
 Main Division and Default for All Divisions/1500:
 Main Division and Default for All Divisions/UB-04:
    Main Division Care Units:
    Anesthesia/1500:
    Reference Lab/1500:
    Reference Lab/UB-04:
    Home Health/UB-04:
 2nd Division Name/1500:
 2nd Division Name/UB-04:
Additional Billing Provider Secondary IDs
 Main Division and Default for All Divisions/1500:
    1st ID
    2nd ID
    3rd ID
    Maximum of 6 additional IDs
 Main Division and Default for All Divisions/UB-04:
    1st ID
    2nd ID
    3rd ID
    Maximum of 6 additional IDs
VA-Laboratory or Facility Secondary IDs
 Main Division and Default for All Divisions/1500:
    1st ID
    2nd ID
    3rd ID
    Maximum of 5 additional IDs

                  ID Parameters
 Attending/Rendering Provider Secondary ID Qualifier (1500):
 Attending/Rendering Provider Secondary ID Qualifier (UB-04):
 Attending/Rendering Secondary ID Requirement: NONE REQUIRED
 Referring Provider Secondary ID Qualifier (1500):
 Referring Provider Secondary ID Requirement:
 Use Attending/Rendering ID as Billing Provider Sec. ID: No
 Transmit no Billing Provider Sec. ID for the Electronic Plan Types:
     HMO
     PPO
 Send VA Lab/Facility IDs or Facility Data: No
```

4.8. Associated Insurance Companies and Copying Physician/Provider Secondary IDs and Additional Billing Provider Secondary IDs.

Patch IB*2.0*320 provides the ability for users to associate multiple Insurance Company entries with each other. If, for example, there are 45 Blue Cross/Blue Shield entries in

the Insurance Company file, users can make one of these entries the Parent company and make 1 to 44 of the other entries a Child company.

Making these associations will cause the software to automatically make the Physician/Provider Secondary IDs and the Additional Billing Provider Secondary IDs the same for all associated companies.

Once these associations are made and the IDs synchronized for all the associated companies, users will be able to Add, Edit and/or Delete IDs for the associated companies from the Parent company. Changes to the IDs from a Child company will be prohibited.

If a situation changes and it becomes necessary for a Child company to have IDs that differ from those of the Parent company, users may disassociated the Child company from the Parent company.

4.8.1 Designate a Parent Insurance Company

Step	Procedure
1	Access the **Insurance Company Editor**.
2	At the **Select INSURANCE COMPANY NAME**: prompt, enter **Blue Cross of California** for this example.
3	At the **Define Insurance Company as Parent or Child**: prompt, enter **Parent**.

```
Insurance Company Editor      Oct 01, 2007@14:27:13          Page:    1 of    9
Insurance Company Information for: BLUE CROSS OF CALIFORNIA
Type of Company: HEALTH INSURANCE                     Currently Active

                          Billing Parameters
  Signature Required?: NO                      Filing Time Frame:
           Reimburse?: WILL REIMBURSE           Type Of Coverage: HEALTH INSURAN
    Mult. Bedsections:                            Billing Phone: 800/933-9146
     Diff. Rev. Codes:                        Verification Phone: 800/933-9146
       One Opt. Visit: NO                     Precert Comp. Name:
  Amb. Sur. Rev. Code:                            Precert Phone: 800/274-7767
  Rx Refill Rev. Code:


                             EDI Parameters
             Transmit?: YES-LIVE                 Insurance Type: GROUP
+         Enter ?? for more actions                                      >>>
BP  Billing/EDI Param     IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen//AC Associate Companies

Define Insurance Company as Parent or Child: P  PARENT
```

Step	Procedure
4	At the Select Action: prompt, enter **Associate Companies** for this example.
5	At the **Select INSURANCE COMPANY NAME**: prompt, enter **BLUE CROSS/BLUE SHIELD 801 PINE ST. CHATTANOOGA,TN** for this example.

Steps 2 - 4 can be repeated to associate additional Insurance Companies with Blue Cross of California.

A Parent – Child association can be removed using the Disassociate Companies action.

To stop an insurance company from being a Parent, all associations with any Child entries must be removed. After disassociating all the Child entries, users may delete the Parent using the '@' sign at the **Define Insurance Company as Parent or Child: PARENT//** prompt.

```
Associated Insurance Co's     Nov 21, 2005@11:13:53          Page:    1 of    1
Parent Insurance Company:
     BLUE CROSS OF CALIFORNIA   PO BOX 60007              LOS ANGELES,CA

     Ins Company Name           Address                   City

     No Children Insurance Companies Found




          Enter ?? for more actions
     Associate Companies                    Exit
     Disassociate Companies
Select Action: Quit// as   Associate Companies

Select Insurance Company: BLUE CROSS/BLUE SHIELD801 PINE ST.  CHATTANOOGA,TN
```

The following screen will display.

```
Associated Insurance Co's     Nov 21, 2005@11:30:25          Page:    1 of    1
Parent Insurance Company:
     BLUE CROSS OF CALIFORNIA   PO BOX 60007              LOS ANGELES,CA

     Ins Company Name           Address                   City
   1 BLUE CROSS FEP             PO BOX 70000              VAN NUYS,CA
   2 BLUE CROSS/BLUE SHIELD     9901 LINN STA RD          LOUISVILLE,KY
   3 BLUE CROSS/BLUE SHIELD     801 PINE ST.              CHATTANOOGA,TN




          Enter ?? for more actions
     Associate Companies                    Exit
     Disassociate Companies
Select Action: Quit//
```

4.8.2 Designate a Child Insurance Company

An insurance company can be designated as a Child, from the Parent insurance company as demonstrated in **Section 3.7.1**.

If users want to quickly define a single insurance company as a Child, they can do this from the Insurance Company Editor.

Step	Procedure
1	Access the **Insurance Company Editor**.
2	At the **Select INSURANCE COMPANY NAME**: prompt, enter **Aetna** for this example.
3	At the **Define Insurance Company as Parent or Child**: prompt, enter **Child** for this example.
4	At the **Associate with which Parent Insurance Company**: prompt, enter the name of the insurance company that will be the Parent.
	'??' will provide a list of available Parent insurance companies.

```
Insurance Company Editor      Oct 01, 2007@14:33:41          Page:    1 of    8
Insurance Company Information for: AETNA
Type of Company: HEALTH INSURANCE                     Currently Inactive

                          Billing Parameters
  Signature Required?: NO                      Filing Time Frame: 12 MOS
           Reimburse?: WILL REIMBURSE           Type Of Coverage: HEALTH INSURAN
    Mult. Bedsections:                            Billing Phone:
     Diff. Rev. Codes:                         Verification Phone:
       One Opt. Visit: NO                      Precert Comp. Name:
  Amb. Sur. Rev. Code:                            Precert Phone:
  Rx Refill Rev. Code:


                             EDI Parameters
              Transmit?: YES-LIVE                Insurance Type: GROUP POLICY
+         Enter ?? for more actions                                        >>>
BP  Billing/EDI Param     IO  Inquiry Office        EA  Edit All
MM  Main Mailing Address  AC  Associate Companies   AI  (In)Activate Company
IC  Inpt Claims Office    ID  Prov IDs/ID Param     CC  Change Insurance Co.
OC  Opt Claims Office     PA  Payer                 DC  Delete Company
PC  Prescr Claims Of      RE  Remarks               VP  View Plans
AO  Appeals Office        SY  Synonyms              EX  Exit
Select Action: Next Screen// ac   Associate Companies

Define Insurance Company as Parent or Child: Child  CHILD
Associate with which Parent Insurance Company: AetNA LIFE INSURANCE       3541 W
INCHESTER RD.         ALLENTOWN     PENNSYLVANIA       Y.....................
```

4.8.3 Copy Physician/Provider Secondary IDs

Individual Physician/Provider Secondary IDs can be entered, edited or deleted one time from the Parent insurance company and these changes will be copied to all associated insurance companies (Child).

This can be done using the following Provider ID Maintenance options:

- Provider ID Maint→PI Provider Insurance IDs;
- Provider ID Maint→II Insurance Co IDs; and
- Provider ID Maint→BI Batch ID Entry

4.8.4 Copy Additional Billing Provider Secondary IDs

When users are done adding, editing or deleting Additional IDs from the Parent insurance company, the changes will be copied to all associated insurance companies.

4.8.5 Synchronizing Associated Insurance Company IDs

There is an IRM option for synchronizing the IDs of a Parent insurance company with all of the associated Child companies. This option is intended as a backup option if the IDs of a Parent have become out of synch with the Child companies due to a system problem.

5. SUBSCRIBER AND PATIENT ID SET-UP

Insurance Companies issue identification numbers to the people that they insure. The person who pays for the insurance policy or whose employer pays for the insurance policy or who receives Medicare is referred to as the subscriber. A veteran can be the subscriber or a veteran can be insured through an insurance policy that belongs to some other subscriber such as the veteran's spouse or parent.

5.1. Subscriber and Patient Insurance Provided IDs

Some insurance companies issue identification numbers only to the subscriber. Some others issue unique identification numbers to each person covered by the subscriber's policy.

Insurance companies can issue both Subscriber Primary and Secondary ID numbers and Patient Primary and Secondary ID numbers.

These ID numbers can be entered when a policy is initially added in VistA through Add a policy. Sometimes the primary IDs will be added during the initial Patient Registration process and placed in the insurance company buffer.

Both Patient and Subscriber, Primary and Secondary IDs can be added or edited at any time using the option Patient Insurance Info View/Edit.

5.1.1 Define Subscriber Primary ID

When the patient is the subscriber, users will be prompted for the Subscriber's Primary ID.

Step	Procedure
1	Access the option **Patient Insurance Info View/Edit**.
2	At the **Select Patient Name**: prompt, enter **IB,PATIENT TWO**.
3	At the **Select Items**: prompt, enter **Policy Edit/View.**
4	At the **Select Policy(s)**: prompt, enter **1** for this example.

```
Patient Insurance Management  Sep 24, 2007@10:18:49          Page:    1 of    1
Insurance Management for Patient: IB,PATIENT TWO IXXXX

    Insurance Co.    Type of Policy   Group        Holder   Effect.    Expires
1   AETNA US HEALTH  COMPREHENSIVE M  655555-19-   SELF     03/06/07
2   BLUE CROSS CA (  PREFERRED PROVI  173084       SPOUSE   05/15/07
3   IB INSURANCE CO  COMPREHENSIVE M  XXXPLANNUM   OTHER    05/16/07
4   NEW YORK LIFE    MEDIGAP (SUPPLE  F            OTHER    09/29/06


          Enter ?? for more actions                                      >>>
AP  Add Policy            EA  Fast Edit All         CP  Change Patient
VP  Policy Edit/View      BU  Benefits Used         WP  Worksheet Print
DP  Delete Policy         VC  Verify Coverage       PC  Print Insurance Cov.
AB  Annual Benefits       RI  Personal Riders       EX  Exit
```

```
Select Item(s): Quit// VP   Policy Edit/View
Select Policy(s):  (1-4): 1...................
```

The following screen will display.

```
Patient Policy Information    Sep 24, 2007@11:20:54          Page:    1 of    6
Expanded Policy Information for: IB,PATIENT TWO  XXX-XX-XXXX
AETNA US HEALTHCARE Insurance Company          ** Plan Currently Active **

  Plan Information                              Insurance Company
    Is Group Plan: YES                            Company: AETNA US HEALTHCARE
       Group Name: FT JAMES CORP                   Street: PO BOX 2561
     Group Number: 655555-19-230                City/State: FT. WAYNE, IN 46801
              BIN:                              Billing Ph: 800/367-4552
              PCN:                              Precert Ph:
     Type of Plan: COMPREHENSIVE MAJOR MED
  Electronic Type: COMMERCIAL
   Plan Filing TF: 2 YRS


  Utilization Review Info                  Effective Dates & Source
          Require UR:                          Effective Date: 03/06/07
+         Enter ?? for more actions
PI  Change Plan Info      IC  Insur. Contact Inf.   CP  Change Policy Plan
UI  UR Info               EM  Employer Info         VC  Verify Coverage
ED  Effective Dates       CV  Add/Edit Coverage     AB  Annual Benefits
SU  Subscriber Update     AC  Add Comment           BU  Benefits Used
IP  Inactivate Plan       EA  Fast Edit All         EX  Exit
Select Action: Next Screen// SU  Subscriber Update
```

Step	Procedure
5	At the Select Action: prompt, enter **Subscriber Update**.
6	At the **Pt. Relationship to Insured**: prompt, enter **Patient**.
	*With Patch IB*2*371, the Whose Insurance? prompt was removed.*
	With Patch IB*2*377, the list of available choices for Pt. Relationship to Insured was modified to have an expanded list of HIPAA valid choices.
7	At the **Name of Insured**: prompt, press **Return** to accept the default of IB,Patient Two.
	*With Patch IB*2*371, users will have the ability to update the patient's name for any patient and any insurance company. This will allow users to make the patient's name match what is on file at the payer even when it is different from what is in the VistA patient file.*
8	At the **Effective Date of Policy**: prompt, press **Return** to accept the default of MAR 6, 2007.
9	At the **Coordination of Benefits**: prompt, enter **Primary** for this example.
10	At the **Source of Information**: prompt, press **Return** to accept the default of Interview.
11	At the **Subscriber Primary ID**: prompt, enter **IDXXXXX** for this example.
12	At the **Do you want to enter/update Subscriber Secondary IDs?** Prompt, press **Return** to accept the default of No.

13 At the **Insured's DOB**: prompt, press **Return** to accept the default.

14 At the **Insured's Sex**: prompt, press **Return** to accept the default.

*With Patch IB*2*361, the Insured's Sex prompt was added. This is required by HIPAA as is the Insured's DOB.*

The Insured's address is not required by HIPAA but HIPAA will not accept a partial address. When the insured is the patient, the patient's address will be defaulted from the patient file.

```
Select Action: Next Screen//  Subscriber Update
PT. RELATIONSHIP TO INSURED: PATIENT
NAME OF INSURED: IB,PATIENT TWO//
EFFECTIVE DATE OF POLICY: MAR 6,2007
INSURANCE EXPIRATION DATE:
PRIMARY CARE PROVIDER:
PRIMARY PROVIDER PHONE:
COORDINATION OF BENEFITS: PRIMARY
SOURCE OF INFORMATION: INTERVIEW//

SUBSCRIBER PRIMARY ID: IDXXXXX

Do you want to enter/update Subscriber Secondary IDs? No//   NO

INSURED'S DOB: XXX XX,XXXX//
INSURED'S SEX: MALE//
INSURED'S BRANCH: NAVY//
INSURED'S RANK:
INSURED'S STREET 1: 123 E.TEST BLVD//
INSURED'S STREET 2:
INSURED'S CITY: CHEYENNE//
INSURED'S STATE: WYOMING//
INSURED'S ZIP: 82001//
```

*Patch IB*2*377 will provide the ability for the Name of the Subscriber and the Subscriber's primary ID (HIC#) to be automatically updated in the Patient's Medicare (WNR) Insurance when an MRA is received in VistA that contains a corrected name and/or ID. The PATIENT file will not be changed.*

5.1.2 Define Subscriber and Patient Primary IDs

When the patient is not the subscriber, users will be prompted for the Patient's Primary ID as well as the Subscriber's Primary ID.

Step	Procedure
1	Access the option **Patient Insurance Info View/Edit**.
2	At the **Select Patient Name**: prompt, enter **IB,PATIENT TWO**.
3	At the **Select Items**: prompt, enter **Policy Edit/View.**
4	At the **Select Policy(s)**: prompt, enter **3** for this example.

```
Patient Insurance Management  Sep 24, 2007@10:18:49          Page:    1 of    1
Insurance Management for Patient: IB,PATIENT TWO I4444

    Insurance Co.    Type of Policy   Group        Holder   Effect.    Expires
1   AETNA US HEALTH  COMPREHENSIVE M  655555-19-   SELF     03/06/07
2   BLUE CROSS CA (  PREFERRED PROVI  173084       SPOUSE   05/15/07
3   IB INSURANCE CO  COMPREHENSIVE M  XXXPLANNUM   SPOUSE   05/16/07
4   NEW YORK LIFE    MEDIGAP (SUPPLE  F            OTHER    09/29/06


         Enter ?? for more actions                                      >>>
AP  Add Policy            EA  Fast Edit All         CP  Change Patient
VP  Policy Edit/View      BU  Benefits Used         WP  Worksheet Print
DP  Delete Policy         VC  Verify Coverage       PC  Print Insurance Cov.
AB  Annual Benefits       RI  Personal Riders       EX  Exit
Select Item(s): Quit// VP   Policy Edit/View
Select Policy(s):  (1-4): 3...................
```

The following screen will display.

```
Patient Policy Information    Sep 24, 2007@10:33:49          Page:    2 of    6
Expanded Policy Information for: IB,PATIENT TWO  XXX-XX-XXXX
IB INSURANCE CO Insurance Company              ** Plan Currently Active **
+
  Subscriber Information                Subscriber's Employer Information
  Whose Insurance: SPOUSE              Emp Sponsored Plan: No
  Subscriber Name:                               Employer:
     Relationship:                      Employment Status:
       Primary ID:                        Retirement Date:
 Coord.  Benefits:                     Claims to Employer: No, Send to Insurance
 Primary Provider:                              Street:
  Prim Prov Phone:                            City/State:
                                                  Phone:

    Insured Person's Information (use Subscriber Update Action)
       Insured's DOB: XX/XX/XXXX           Str 1: 123 E.TEST BLVD
+         Enter ?? for more actions
PI  Change Plan Info      IC  Insur. Contact Inf.   CP  Change Policy Plan
UI  UR Info               EM  Employer Info         VC  Verify Coverage
ED  Effective Dates       CV  Add/Edit Coverage     AB  Annual Benefits
SU  Subscriber Update     AC  Add Comment           BU  Benefits Used
IP  Inactivate Plan       EA  Fast Edit All         EX  Exit
Select Action: Next Screen// SU  Subscriber Update
```

Step	Procedure
5	At the **Select Action**: prompt, enter **Subscriber Update**.
6	At the **PT. RELATIONSHIP TO INSURED:** prompt, enter **SPOUSE** for this example.
	*With Patch IB*2*377, an expanded list of HIPAA compliant codes for Pt. Relationship to Insured, was added.*
	*With Patch IB*2*371, the Whose Insurance? prompt was removed.*
7	At the **Name of Insured**: prompt, enter **IB,Spouse Two** for this example.
8	At the **Effective Date of Policy**: prompt, press **Return** to accept the default of May 15, 2007.

9 At the **Coordination of Benefits**: prompt, enter **Secondary** for this example.

10 At the **Source of Information**: prompt, press **Return** to accept the default of Interview.

11 At the **Subscriber Primary ID**: prompt, enter **XXXXXID** for this example.

12 At the **Do you want to enter/update Subscriber Secondary IDs?** Prompt, press **Return** to accept the default of No.

13 At the **Patient Primary ID**: prompt, enter **XXXXXID2** for this example.

14 At the **Do you want to enter/update Patient Secondary IDs?** Prompt, press **Return** to accept the default of No.

15 At the **Insured's DOB**: prompt, enter **August 12, 1945** for this example.

16 At the **Insured's Sex**: prompt, enter **Female** for this example.

*With Patch IB*2*361, the Insured's Sex prompt was added. This is required by HIPAA as is the Insured's DOB.*

If the Patient's Relationship to the Insured is spouse, then the patient's address will be the default address of the Insured. Users may enter different values if the spouse's address is different from the patient's.

The Insured's address is not required by HIPAA but HIPAA will not accept a partial address.

```
Select Action: Next Screen// SU   Subscriber Update
PT. RELATIONSHIP TO INSURED: SPOUSE//
NAME OF INSURED: IB,SPOUSE TWO
EFFECTIVE DATE OF POLICY: MAY 15,2007
INSURANCE EXPIRATION DATE:
PRIMARY CARE PROVIDER:
PRIMARY PROVIDER PHONE:
COORDINATION OF BENEFITS: SECONDARY
SOURCE OF INFORMATION: INTERVIEW//

SUBSCRIBER PRIMARY ID: XXXXXID

Do you want to enter/update Subscriber Secondary IDs? No//   NO

PATIENT PRIMARY ID: XXXXXID2

Do you want to enter/update Patient Secondary IDs? No//   NO

INSURED'S DOB: AUG 12,1945
INSURED'S SEX: FEMALE
INSURED'S BRANCH:
INSURED'S RANK:
INSURED'S STREET 1: 123 E.TEST BLVD//
INSURED'S STREET 2:
INSURED'S CITY: CHEYENNE//
INSURED'S STATE: WYOMING//
INSURED'S ZIP: 82001//
```

5.1.3 Define Subscriber and Patient Secondary IDs

In addition to Subscriber and Patient Primary IDs, it is possible for insurance companies to issue secondary IDs, though this is very unusual. A subscriber or a patient may also have one or more secondary IDs of the following types:

- 23 Client Number
- IG Insurance Policy Number
- SY Social Security Number

```
SUBSCRIBER PRIMARY ID: XXXXXID//

Do you want to enter/update Subscriber Secondary IDs? No// y  YES

SUBSCRIBER'S SEC QUALIFIER(1):??
     Enter a Qualifier to identify the type of ID number.
     Choose from:
       23       Client Number
       IG       Insurance Policy Number
       SY       Social Security Number
SUBSCRIBER'S SEC QUALIFIER(1): IG  Insurance Policy Number
SUBSCRIBER'S SEC ID(1): XXXXID2
SUBSCRIBER'S SEC QUALIFIER(2):

PATIENT PRIMARY ID: IDXXXXX//

Do you want to enter/update Patient Secondary IDs? No// y  YES

PATIENT'S SEC QUALIFIER(1): IG  Insurance Policy Number
PATIENT'S SECONDARY ID(1): ID2XXXX
PATIENT'S SEC QUALIFIER(2):
```

Step	Procedure
1	Access **Subscriber Update** again.
2	At the **Do you want to enter/update Subscriber Secondary IDs? No//:** prompt, enter **Yes**.
3	At the **Subscriber's Sec Qualifier (1):**: prompt, enter **IG** for this example.
	23 Client Number is used for claims to the Indian Health Service/Contract Health Services (HIS/CHS).
	VistA will not allow users to enter SY for SNN if the payer is Medicare. Medicare will not accept the SSN as a subscriber's secondary ID.
4	At the **Subscriber's Sec ID (1)**: prompt, enter **XXXXID2** for this example.
5	At the **Subscriber's Sec Qualifier (2):**: prompt, press **Return** if you do not want to add another ID.
6	At the **Patient Primary ID (1)**: prompt, press **Return** to accept the default.
7	At the **Do you want to enter/update Patient Secondary IDs? No//:** prompt, enter **Yes**.
8	At the **Patient's Sec Qualifier (1):**: prompt, enter **IG** for this example.
9	At the **Patient's Sec ID (1)**: prompt, enter **ID2XXXX** for this example.
10	At the **Patient's Sec Qualifier (2):**: prompt, press **Return** if you do not want to add another ID.

6. ENTERING ELECTRONIC CLAIMS

This section briefly identifies the screens used in the billing process that contain fields critical to EDI billing. It is important that all the data transmitted in an electronic claim be accurate and appropriate. This section is just meant to highlight some specific fields that pertain to electronic processing.

6.1. Screen 3 – Payer Information

6.1.1 EDI Fields

Section 1 – Transmit	When a payer has been set up to transmit claims electronically, this field will say "Yes". If the field says "No" the claim will be printed locally.
Section 2 – Primary, Secondary and Tertiary Payer	These fields display the Billing Provider Secondary IDs for the payers on the bill. These IDs are defined in the Insurance Company Editor. *Note: If users set the ID Parameter: Send Attending/Rendering ID as Billing Provider Sec. ID? to Yes for a payer on the claim, the Attending/Rendering ID will be sent.*
Section 3 – Mailing Address	This field should contain a valid mailing address for the current payer. In order to avoid EDI errors, there should be no periods or dashes such as P.O. Box, Winston-Salem, St. Paul, etc. *Exception: Medicare does not have a valid address.*
Section 3 – Electronic ID	This field contains the Inst Payer Primary ID or Prof Payer Primary ID defined in the Insurance Company Editor. Payer Primary IDs are provided by the clearinghouse and can be found at https://access.emdeon.com/PayerLists/

```
IB,PATIENT 1   XXX-XX-XXXX   BILL#: K501XXX - Inpat/1500        SCREEN <3>
================================================================================
                                PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.           Form Type: CMS-1500
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer : MRA NEEDED FROM MEDICARE    Transmit: Yes

    Ins 1: MEDICARE (WNR)     WILL NOT REIMBURSE   Policy #: XXXXXXXXA
    Grp #: PART A             Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PART A            Insd Sex: MALE       Insured: IB,PATIENT 1

    Ins 2: BLUE CROSS OF CA                        Policy #: MES3456
    Grp #: PLAN 2             Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PROTECTION PLUS   Insd Sex: MALE       Insured: IB,PATIENT 1

[2] Billing Provider Secondary IDs:
    Primary Payer: 670899
    Secondary Payer: XXXXXX1X              Tertiary Payer:

[3] Mailing Address :                                  Electronic ID: XXXXID
    NO MAILING ADDRESS HAS BEEN SPECIFIED!   (Patient has Medicare)
    Send Bill to PAYER listed above.
<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

The 3-line mailing address displayed here is used also used by the clearinghouse to look up the Electronic ID for the payer when a claim is sent without a defined Electronic Bill ID.

6.1.2 Using Care Units for Billing Provider Secondary IDs

Section 3 of Billing Screen 3 contains fields for the Billing Provider Secondary IDs for the primary, secondary and tertiary payers on a claim. Normally the default values for the site or the defined values for the division on the claim populate these fields. If any insurance company on the claim requires different Billing Provider Secondary IDs based upon Care Units, users can change the default values to the value defined for the Care Unit where the services were provided.

Step	Procedure
1	At the **<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT**: prompt, enter **2**.
2	At the **Current Bill Payer Sequence**: prompt, press **Return** to accept the default.
3	At the **Define Primary Payer ID by Care Unit?**: prompt, press **Return** to accept the default.
4	At the **Primary Payer ID**: prompt, press **Return** to accept the default.
5	At the **Define Secondary Payer ID by Care Unit?**: prompt, enter **Yes** for this example.
6	At the **Division**: prompt, press **Return** to accept the default for this example.
7	At the **Care Unit**: prompt, enter **Anesthesia** for this example.
8	At the **Secondary Payer ID**: prompt, press **Return** to accept the default.
	Note: The Care Units must be defined in Provider ID Maintenance and the ID numbers must be defined in the Insurance Company Editor. ***Refer to***

Section 3.2.2.3 and Section 3.5.2

```
IB,PATIENT 1   XXX-XX-XXXX   BILL#: K501XXX - Inpat/1500        SCREEN <3>
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.           Form Type: CMS-1500
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer : MRA NEEDED FROM MEDICARE    Transmit: Yes

    Ins 1: MEDICARE (WNR)     WILL NOT REIMBURSE   Policy #: XXXXXXXXA
    Grp #: PART A             Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PART A            Insd Sex: MALE       Insured: IB,PATIENT 1

    Ins 2: BLUE CROSS OF CA                        Policy #: MES3456
    Grp #: PLAN 2             Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: PROTECTION PLUS   Insd Sex: MALE       Insured: IB,PATIENT 1

[2] Billing Provider Secondary IDs:
    Primary Payer: 670899
    Secondary Payer: XXXXXX1X              Tertiary Payer:

[3] Mailing Address :                                  Electronic ID: XXXXID
    NO MAILING ADDRESS HAS BEEN SPECIFIED!   (Patient has Medicare)
    Send Bill to PAYER listed above.
<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT: 2
Current Bill Payer Sequence: PRIMARY INSURANCE//
Define Primary Payer ID by Care Unit? No//
Primary Payer ID: 670899//
Define Secondary Payer ID by Care Unit? No//Yes
Division: Main Division//
Care Unit: ??
       1 Anesthesia
       2 Reference Lab
       3 Home Health
Care Unit: 1 Anesthesia
Secondary Payer ID: XXXXXXX//
```

6.2. Screen 8 – Physician/Provider and Print Information

6.2.1 EDI Fields UB-04/CMS-1500

Section 2 – Patient Reason for Visit DX	For outpatient, institutional claims, this section will contain the Patient Reason for Visit diagnoses.
Section 3/3 – Providers	When a Physician/Provider is entered here, the system finds the appropriate IDs and Taxonomy Codes for him/her. The Primary IDs are the providers' SSNs and their secondary IDs are those IDs that users have defined as the provider's own or as those provided by an insurance company.
Section 4 – Other Facility, CLIA#, Mammography Certification Number	These are the sections through which outside facilities are entered. The primary and secondary Laboratory or Facility IDs and Taxonomy Codes are then transmitted with the claim. The CLIA# and Mammography Certification Number can also be sent with a professional laboratory claim or

	mammography claim.
Section 5/7 – Billing Provider	These sections display the calculated Billing Provider and the Billing Provider's Taxonomy Code. Only the taxonomy code can be edited
Section 6/8 – Force to Print	Users can set this field to force a claim to print either locally or at the clearinghouse.
Section 7/9 – Provider ID Maint	This is a link to the Provider ID Maintenance function.

```
IB,PATIENT2   000-00-0000   BILL#: K300XX - Outpat/UB-04  SCREEN<8>
================================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
     - FL-80           : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
    Admission Source   : PHYSICIAN REFERRAL
[2] Pt Reason f/Visit : COUGH - 786.2
[3] Providers         :
     - ATTENDING (MD) : IB,DOCTOR 2          Taxonomy: UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
[5] Billing Provider  : CHEYENNE VAMC
    Taxonomy Code     : 282N00000X
[6] Force To Print?   : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

```
IB,PATIENT 3   000-00-0000   BILL#: K600XX - Outpat/1500        SCREEN <8>
================================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - RENDERING (MD)  : IB,DOCTOR 1        Taxonomy: UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data  : UNSPECIFIED [NOT REQUIRED]
[6] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider   : CHEYENNE VAMC
    Taxonomy Code      : 282N00000X
[8] Force To Print?    : NO FORCED PRINT
[9] Provider ID Maint  : (Edit Provider ID information)

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:
```

6.3. UB-04 Claims

The following screens provide a simplified example of a UB-04 claim:

Step	Procedure
1	When processing a UB-04 claim, information on Screens 1 and 2 should be reviewed for correctness. Press the **Return** key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press **Return** to continue to Screen 5.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB-04 SCREEN <3>
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: UB-04
    Responsible: INSURER                    Payer Sequence: Primary
    Bill Payer : Blue Cross Fep              Transmit: Yes

    Ins 1: Blue Cross Fep                         Policy #: RXXXXXXXXX
    Grp #: 100                Whose: VETERAN      Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY   Insd Sex: MALE      Insured: IB,PATIENT3

[2] Primary  : 010100
    Secondary:                              Tertiary :

[3] Mailing Address :                                  Electronic ID: 12B54
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL  352020401


<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
3	On Screen 5, enter sections **1-7** to type in the diagnosis information, the services/procedures provided and the date of service. Include the Occurrence and Condition Code when required. Press the **Return** key to move to Screen 7.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB-04  SCREEN <5>
================================================================================
                         EVENT - OUTPATIENT INFORMATION
[1] Event Date : XXX XX, XXXX
[2] Prin. Diag.: ABDOM PAIN, L L QUADR - 789.04
    Other Diag.: BENIGN NEOPLASM LG BOWEL - 211.3
    Other Diag.: DIVERTICULOSIS OF COLON - 562.10
[3] OP Visits  : XXX XX, XXXX
[4] Cod. Method: HCPCS
    CPT Code   : LESION REMOVE COLONOSCOPY 45384              XXX XX, XXXX
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : ONSET OF SYMPTOMS/ILLNESS           XXX XX, XXXX
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]


<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
4	If all information has been entered correctly, Screen 7 will be auto-populated (as shown below) with the necessary information to send the claim electronically. *Make sure that the Disch Stat field in Section 1 is populated*. Press the **Return** key to move to Screen 8.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB-04  SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type    : 131              Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: UNSPECIFIED      Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED         Timeframe: ADMIT THRU DISCHARGE
    Charge Type : INSTITUTIONAL      Disch Stat: DISCHARGED TO HOME OR SELF CAR
    Form Type   : UB-04                Division: MONTGOMERY VAMC
[2] Sensitive?  : UNSPECIFIED                  Assignment: YES
[3] Bill From   : XXX XX, XXXX                    Bill To: XXX XX, XXXX
[4] OP Visits   : XXX XX, XXXX
[5] Rev. Code   : 750-GASTR-INST SVS     45384      $2,137.44  OUTPATIENT VISIT
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :   $2,137.44
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED

<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
5	On Screen 8, enter **3** to enter the name of the Attending Physician. A UB-04 claim can also contain an Operating and/or Other Physician.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB-04  SCREEN<8>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
     - FL-80          : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)        : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)  : UNSPECIFIED [NOT REQUIRED]
    Admission Source  : PHYSICIAN REFERRAL
[2] Pt Reason f/Visit : COUGH - 786.2
[3] Providers         :
     - ATTENDING (MD) : UNSPECIFIED          Taxonomy: UNSPECIFIED
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
[5] Billing Provider  : CHEYENNE VAMC
    Taxonomy Code     : 282N00000X
[6] Force To Print?   : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

The Primary ID (SSN) for the Attending, Operating or Other Physician is always transmitted with a claim.

The Secondary IDs for the Attending, Operating or Other Physician are

determined from what the user enters and from entries in Provider ID Maintenance.

If users have set a default ID type and made it required for the current or other payers, the claim can not be authorized if the physician does not have an ID of that type defined.

When a provider is first added to Screen 8, the user will be shown a screen that contains a list of all the provider's IDs, the ID type and, optionally, the care unit on file for the provider's IDs. This will include the provider's own IDs, the provider's IDs assigned by the insurance company, the insurance company defaults, if any, and all IDs assigned to the provider by care unit.

The first 2 entries in this list will always be:
1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY

Any ID entered on screen 8 will automatically override any default provider secondary ID that exists for the same ID Qualifier for this claim ONLY.

```
**** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS CA (WY)
PROVIDER: IB,PHYSICIAN4 (ATTENDING)

INS. COMPANY'S DEFAULT SECONDARY ID TYPE IS: BLUE CROSS ID

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

  1    -  NO SECONDARY ID NEEDED
  2    -  ADD AN ID FOR THIS CLAIM ONLY
  3    -  <DEFAULT> XXXXBCROSS              BLUE CROSS ID
  4    -  WYXXXX                            ST LIC (WY)

Selection: 3//
```

If there is a default secondary ID found, based on the insurance company parameters and the Provider ID is defined in the Provider ID Maintenance, this will be the 3rd entry in the list and will be preceded with the text <**DEFAULT**>. If this ID exists, the default for the Selection prompt will be **3.**

If no default ID exists, the default for the selection prompt will be **1** – No Secondary ID needed.

Any care units assigned to an ID using Provider ID Maintenance are displayed at the far right of the ID line. You no longer have to enter a care unit on the bill.

You can make a selection from the list by choosing the number preceding the ID you want to assign to the provider for the bill. This will add both the ID Qualifier and the ID number to the claim.

Note: If the Provider has multiple IDs defined, the one you select or the new one time only ID that you enter, will appear on Screen 8 and will be the first ID sent but the system will still transmit the remaining IDs. The one you select will just be the first one transmitted. The maximum number that will be transmitted is five.

If none of the IDs are valid for the provider for the claim, you can add a new ID *for this claim only*.

Step	Procedure
6	At the **Selection** prompt, type **2** to add an ID for this claim only.
7	At the **PRIM INS PERF PROV SECONDARY ID TYPE**: prompt, enter the ID Qualifier that the primary payer requires as a secondary ID type. Type two question marks (**??**) to see the list of possible choices. (For this example, type **Location Number** as the secondary ID Qualifier).
8	At the **PRIM INS PERF PROV SECONDARY ID**: prompt, enter the **ID** number provided by the payer. In this example, type **XXXXA**.

```
Selection: 3// 2
  PRIM INS PERF PROV SECONDARY ID TYPE: ??
   Choose from:
   BLUE CROSS ID
   BLUE SHIELD ID
   COMMERCIAL ID
   LOCATION NUMBER
   MEDICARE PART A
   MEDICARE PART B

  PRIM INS PERF PROV SECONDARY ID TYPE: LOCATION NUMBER
  PRIM INS PERF PROV SECONDARY ID: XXXXA
```

After an ID and ID Qualifier are added to the claim for a provider, the provider's name and the selected ID are displayed on Screen 8. These fields can be edited/deleted.

If a physician/provider is deleted, the next time the provider entry is accessed, the list of valid IDs will be displayed again.

Valid Secondary ID Types for Current Payer	
Attending/Operating/Other (UB-04)	State License; Blue Cross; Blue Shield; Medicare Part A; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider
Rendering/Referring/Supervising (1500)	State License; Blue Shield; Medicare Part B; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider

Valid Secondary ID Types for Other Payer (Not Current)	
Attending/Operating/Other (UB-04)	Blue Cross; Blue Shield; Medicare;

	Commercial ID; Location Number
Rendering (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Referring (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Supervising (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Network ID

Step	Procedure
9	At the **<RET> to Continue**: prompt (any screen), enter **?PRV** to see summary information about a particular provider.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB-04  SCREEN<8>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
     - FL-80           : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
    Admission Source   : PHYSICIAN REFERRAL
[2] Pt Reason f/Visit : COUGH - 786.2
[3] Providers         :
     - ATTENDING (MD) : IB,DOCTOR4          Taxonomy: 208G00000X  (33)
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
[5] Billing Provider  : CHEYENNE VAMC
    Taxonomy Code     : 282N00000X
[6] Force To Print?   : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)


<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?PRV
(V)A or (N)on-VA Provider: V// A PROVIDER

This is a display of provider specific information.
This bill is UB-04/Outpatient

The valid provider functions for this bill are:
2  OPERATING   OPTIONAL - NOT ON BILL
4  ATTENDING   REQUIRED - ALREADY ON BILL
9  OTHER       OPTIONAL - NOT ON BILL


Select PROVIDER NAME: IB,PHYSICIAN4       PI

--------------------------------------------------------------------------------
 Signature Name: PHYSICIAN4 IB
Signature Title: STAFF PSYCHIATRIST
         Degree: BA
            NPI: 1234567891

     License(s): None Active on X/X/XX

   Person Class: None Active on X/X/XX

RC Provider Group: None
--------------------------------------------------------------------------------

Select PROVIDER NAME:
```

Step	Procedure
10	At the **<RET> to Continue**: prompt (any screen), enter **?ID** to see what IDs will be transmitted with the claim.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/UB-04  SCREEN<8>
================================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Bill Remarks
     - FL-80          : UNSPECIFIED [NOT REQUIRED]
    ICN/DCN(s)        : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)  : UNSPECIFIED [NOT REQUIRED]
    Admission Source  : PHYSICIAN REFERRAL
[2] Pt Reason f/Visit : COUGH - 786.2
[3] Providers         :
     - ATTENDING (MD) : IB,DOCTOR4          Taxonomy: 208G00000X  (33)
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
[5] Billing Provider  : CHEYENNE VAMC
    Taxonomy Code     : 282N00000X
[6] Force To Print?   : NO FORCED PRINT
[7] Provider ID Maint : (Edit Provider ID information)



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?ID


IF THIS BILL IS TRANSMITTED ELECTRONICALLY, THE FOLLOWING IDS WILL BE SENT:
  PRIMARY INS CO: BLUE CROSS CA (WY) <<<Current Ins
SECONDARY INS CO: TPM TRUST

PROVIDER IDs: (VISTA RECORDS OP1,OP2,OP4,OP8,OP9,OPR2,OPR3,OPR4,OPR5,OPR8):
     ATTENDING/RENDERING: IB,PHYSICIAN4
       NPI:                        0000000006
       SSN:                        000000000
        SECONDARY IDs
         (P) LOCATION NUMBER        XXXXA
         (P) BLUE CROSS ID          XXXXBCROSS
         (P) ST LIC (WY)            WYXXXX
```

Step	Procedure
11	Press the **Return** key to move through the fields. At the **Want To Authorize Bill At This Time?:** and **Authorize Bill Generation?:** prompts, enter **Yes**. The claim is now complete and will be transmitted to the FSC in Austin at the next regularly scheduled transmission time.

```
WANT TO EDIT SCREENS? NO// <ENTER>
WANT TO AUTHORIZE BILL AT THIS TIME? No// YES
AUTHORIZE BILL GENERATION?: YES
Adding  bill to BILL TRANSMISSION File.

  Bill will be submitted electronically
Passing completed Bill to Accounts Receivable.  Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

This Bill Can Not Be Printed Until Transmit Confirmed


This Outpatient INSTITUTIONAL bill may have corresponding PROFESSIONAL
charges.
```

6.4. CMS-1500 Claims

The following screens provide a simplified example of a CMS-1500 claim.

Step	Procedure
1	When processing a CMS-1500 claim, information on Screens 1 and 2 should be reviewed for correctness. Press the **Return** key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press **Return** to continue to Screen 4.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/1500 SCREEN <3>
================================================================================
                                PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: CMS 1500
    Responsible: INSURER                    Payer Sequence: Primary
    Bill Payer : Blue Cross Fep              Transmit: Yes

    Ins 1: Blue Cross Fep                         Policy #: R00000000
    Grp #: 100                Whose: VETERAN      Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY   Insd Sex: MALE      Insured: IB,PATIENT3

[2] Billing Provider Secondary IDs:
    Primary  : 010100
    Secondary:                              Tertiary :

[3] Mailing Address :                                  Electronic ID: 12B54
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL  352020401

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
3	Specify the correct diagnosis and procedure code(s) that must be on this claim. Press the **Return** key to move to Screen 6.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Inpat/1500 SCREEN <4>
================================================================================
    EVENT - INPATIENT INFORMATION
[1] Admission : XXX XX, XXXX, 10:56:29 pm          Accident Hour: UNSPECIFIED
    Source : CLINIC REFERRAL                          Type: URGENT
[2] Discharge.: XXX XX, XXXX @14:59
    Status:  DISCHARGED TO HOME OR SELF CARE
[3] Prin. Diag.: URIN TRACT INFECTION NOS - 559.0
    Other Diag.: PROTEIN INFECTION NOS - 041.6
    Other Diag.: HYPERTROPHY BENIGN PROSTATE - 600.0
[4] Cod. Method: HCPCS
    CPT Code    : US EXAM, ABDOM, COMPLETE 76700-26        600.0    XXX XX, XXXX
[5] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[6] Occ. Code  : ONSET OF SYMPTOMS/ILLNESS          XXX XX, XXXX
[7] Cond. Code : MEDICAL APPROPRIATENESS
[8] Value Code : UNSPECIFIED [NOT REQUIRED]
```

Step	Procedure
4	Verify that the Form Type is CMS-1500 and that the date of billing is entered. Make sure the Disch Stat field is populated. If all the data have been entered correctly, section 4 should display the correct revenue codes and costs. Press the **Return** to move to Screen 8.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/1500 SCREEN <6>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 131             Loc. of Care: HOSPITAL - INPT OR OPT(INCLU
    Covered Days: UNSPECIFIED     Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED        Timeframe: ADMIT THRU DISCHARGE
    Charge Type : INSTITUTIONAL     Disch Stat:
    Form Type   : CMS-1500            Division: MONTGOMERY VAMC
[2] Sensitive?  : UNSPECIFIED                  Assignment: YES
[3] Bill From   : XXX XX, XXXX                  Bill To: XXX XX, XXXX
[4] Bedsection : GENERAL MEDICAL SERVICE
    LOS    : 1
[5] Rev. Code   : 500-OUTPATIENT SVCS     99221      $137.44  GENERAL MEDICAL
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :   $137.44
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED



<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
5	From Screen 8, select section **3** to enter the name of the **Rendering Provider**. Enter a **Referring Provider** if required by the payer for the procedure codes on the claim.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/1500 SCREEN <8>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - RENDERING (MD)  : IB,DOCTOR4            Taxonomy: 000000000X
                                [P]XXXXBCROSS
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data  : UNSPECIFIED [NOT REQUIRED]
[6] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider   : CHEYENNE VAMC
    Taxonomy Code      : 282N00000X
[8] Force To Print?    : NO FORCED PRINT
[9] Provider ID Maint  : (Edit Provider ID information)

<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:
```

The Primary ID (SSN) for the Attending, Operating or Other Physician is always transmitted with a claim.

The Secondary IDs for the Attending, Operating or Other Physician are determined from what the user enters and from entries in Provider ID Maintenance.

If users have set a default ID type and made it required for the current or other payer, the claim can not be authorized if the physician does not have an ID of that type defined.

When a provider is first added to screen 8, the user will be shown a screen that contains a list of all the provider's IDs, the ID type and, optionally, the care unit on file for the provider's IDs. This will include the provider's own IDs, the provider's IDs assigned by the insurance company, the insurance company defaults, if any, and all IDs assigned to the provider by care unit.

The first 2 entries in this list will always be:
1 - NO SECONDARY ID NEEDED
2 - ADD AN ID FOR THIS CLAIM ONLY

Any ID entered on screen 8 will automatically override any default provider secondary ID that exists for the same ID Qualifier for this claim ONLY.

```
**** SECONDARY PERFORMING PROVIDER IDs ****

PRIMARY INSURANCE CO: BLUE CROSS CA (WY)
PROVIDER: IB,PHYSICIAN4 (ATTENDING)

INS. COMPANY'S DEFAULT SECONDARY ID TYPE IS: BLUE SHIELD ID

SELECT A SECONDARY ID OR ACTION FROM THE LIST BELOW:

  1    -  NO SECONDARY ID NEEDED
  2    -  ADD AN ID FOR THIS CLAIM ONLY
  3    -  <DEFAULT> XXXXBSHIELD            BLUE SHIELD ID
  4    -  WYXXXX                          ST LIC (WY)

Selection: 3//
```

If there is a default secondary ID found, based on the insurance company parameters and the Provider ID is defined in the Provider ID Maintenance, this will be the 3rd entry in the list and will be preceded with the text <**DEFAULT**>. If this ID exists, the default for the Selection prompt will be **3.**

If no default ID exists, the default for the selection prompt will be **1** – No Secondary ID needed.

Any care units assigned to an ID using Provider ID Maintenance are displayed at the far right of the ID line. You no longer have to enter a care unit on the bill.

You can make a selection from the list by choosing the number preceding the ID you want to assign to the provider for the bill. This will add both the ID Qualifier and the ID number to the claim.

Note: If the Provider has multiple IDs defined, the one you select or the new one time only ID that you enter, will appear on Screen 8 and will be the first ID sent but the system will still transmit the remaining IDs. The one you select will just be the first one transmitted. The maximum number that will be transmitted is five.

If none of the IDs are valid for the provider for the claim, you can add a new ID *for this claim only*.

Step	Procedure
6	At the **Selection** prompt, type **2** to add an ID for this claim only.
7	At the **PRIM INS PERF PROV SECONDARY ID TYPE**: prompt, enter the ID Qualifier that the primary payer requires as a secondary ID type. Type two question marks (**??**) to see the list of possible choices. (For this example, type **Location Number** as the secondary ID Qualifier).
8	At the **PRIM INS PERF PROV SECONDARY ID**: prompt, enter the **ID** number provided by the payer. In this example, type **XXXXA**.

```
Selection: 3// 2
  PRIM INS PERF PROV SECONDARY ID TYPE: ??
   Choose from:
   BLUE CROSS ID
   BLUE SHIELD ID
   COMMERCIAL ID
   LOCATION NUMBER
   MEDICARE PART A
   MEDICARE PART B

  PRIM INS PERF PROV SECONDARY ID TYPE: LOCATION NUMBER
  PRIM INS PERF PROV SECONDARY ID: XXXXA
```

After an ID and ID Qualifier are added to the claim for a provider, the provider's name and the selected ID are displayed on Screen 8. These fields can be edited/deleted.

If a physician/provider is deleted, the next time the provider entry is accessed, the list of valid IDs will be displayed again.

Valid Secondary ID Types for Current Payer	
Attending/Operating/Other (UB-04)	State License; Blue Cross; Blue Shield; Medicare Part A; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider
Rendering/Referring/Supervising (1500)	State License; Blue Shield; Medicare Part B; UPIN; TRICARE; Commercial ID; Location Number; Network ID; SSN; State Industrial and Accident Provider

Valid Secondary ID Types for Other Payer (Not Current)	
Attending/Operating/Other (UB-04)	Blue Cross; Blue Shield; Medicare Part A and Part B; UPIN; TRICARE; Commercial ID; Location Number
Rendering (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Referring (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Location Number; Network ID
Supervising (1500)	Blue Shield; Medicare Part A and Part B; Commercial ID; Network ID

Step	Procedure
9	At the **<RET> to Continue**: prompt (any screen), enter **?PRV** to see summary information about a particular provider.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/1500  SCREEN<8>
================================================================================
                          BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - RENDERING (MD)  : IB,DOCTOR4            Taxonomy: 390200000X
                                 [P]XXXXBCROSS
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data  : UNSPECIFIED [NOT REQUIRED]
[6] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider   : MONTGOMERY VAMC
    Taxonomy Code      : 282N00000X
[8] Force To Print?    : NO FORCED PRINT
[9] Provider ID Maint  : (Edit Provider ID information)


<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:?PRV
(V)A or (N)on-VA Provider: V// NON-VA PROVIDER


Select NON-VA PROVIDER NAME: IB,OUTSIDEDOC       OI

--------------------------------------------------------------------------------
 Signature Name: OUTSIDEDOC IB
            NPI: 1234567892

     License(s): None Active on X/X/XX

   Person Class: V115500
  PROVIDER TYPE: Allopathic and Osteopathic Physicians
 CLASSIFICATION: Resident, Allopathic (includes Interns, Residents, Fellows)
 SPECIALIZATION:
       TAXONOMY: 390200000X (144)
--------------------------------------------------------------------------------

Select NON-VA PROVIDER NAME:
```

Step	Procedure
10	At the **<RET> to Continue**: prompt (any screen), enter **?ID** to see what IDs will be transmitted with the claim.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Inpat/1500  SCREEN<8>
================================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - RENDERING (MD)  : IB,DOCTOR4           Taxonomy: 000000000X
                                [P]XXXXBCROSS
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : UNSPECIFIED [NOT REQUIRED]
    Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data  : UNSPECIFIED [NOT REQUIRED]
[6] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider   : MONTGOMERY VAMC
    Taxonomy Code      : 282N00000X
[8] Force To Print?    : NO FORCED PRINT
[9] Provider ID Maint  : (Edit Provider ID information)


<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT: ?ID


IF THIS BILL IS TRANSMITTED ELECTRONICALLY, THE FOLLOWING IDS WILL BE SENT:
  PRIMARY INS CO: BLUE CROSS CA (WY) <<<Current Ins
SECONDARY INS CO: TPM TRUST

PROVIDER IDs: (VISTA RECORDS OP1,OP2,OP4,OP8,OP9,OPR2,OPR3,OPR4,OPR5,OPR8):
     ATTENDING/RENDERING: IB,PHYSICIAN4
       NPI:                       000000000X
       SSN:                       XXXXXXXXX
        SECONDARY IDs
         (P) LOCATION NUMBER        XXXXA
         (P) BLUE CROSS ID          XXXXBCROSS
         (P) ST LIC (WY)            WYXXXX
```

Step	Procedure
11	Press the **Return** key to move through the fields. At the **Want To Authorize Bill At This Time?:** and **Authorize Bill Generation?:** prompts, enter **Yes**. The claim is now complete and will be transmitted to the FSC in Austin at the next regularly scheduled transmission time.

```
Executing A/R edits
No A/R errors found

WANT TO EDIT SCREENS? NO//

THIS BILL WILL BE TRANSMITTED ELECTRONICALLY

WANT TO AUTHORIZE BILL AT THIS TIME? No// YES
AUTHORIZE BILL GENERATION?: YES
  Adding  bill to BILL TRANSMISSION File.

  Bill will be submitted electronically
Passing completed Bill to Accounts Receivable.  Bill is no longer editable.
Completed Bill Successfully sent to Accounts Receivable.

This Bill Can Not Be Printed Until Transmit Confirmed
```

6.5. Lab Claims

EDI Enhanced HIPAA format allows users to enter a CLIA# when billing for certain laboratory procedures. The VA's CLIA # must be entered on Screen 8 when billing a Medicare secondary payer for laboratory and pathology procedures that are not reimbursed in full by Medicare. A list of these CPT codes may be found on the MRA Training page of VistA University: http://vaww.vistau.med.va.gov/VistaU/e-bp/e-mra.htm

The following screens provide a simplified example of a lab claim:

Step	Procedure
1	When processing a Laboratory claim, information on Screens 1 and 2 should be reviewed for correctness. Press the **Return** key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press **Return** to continue to Screen 5.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/1500 SCREEN <3>
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.          Form Type: CMS 1500
    Responsible: INSURER                    Payer Sequence: Primary
    Bill Payer : Blue Cross Fep              Transmit: Yes

    Ins 1: Blue Cross Fep                         Policy #: R00000000
    Grp #: 100               Whose: VETERAN       Rel to Insd: PATIENT
    Grp Nm: STANDARD FAMILY  Insd Sex: MALE       Insured: IB,PATIENT3


[2] Billing Provider Secondary IDs:
    Primary  : 010100
    Secondary:                              Tertiary :

[3] Mailing Address :                                  Electronic ID: 12B54
    Blue Cross Fep
    P O Box 10401
    Birmingham, AL  352020401


<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
3	Specify the correct diagnosis and procedure code(s) that must be on this claim. Press the **Return** key to move to Screen 7.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/1500  SCREEN <5>
================================================================================
                        EVENT - OUTPATIENT INFORMATION
[1] Event Date : XXX XX,XXXX
[2] Prin. Diag.: URINARY FREQUENCY - 788.41
[3] OP Visits  : XXX XX,XXXX
[4] Cod. Method: HCPCS
    CPT Code   : URINALYSIS, AUTO W/SCOPE 81001        XXX XX,XXXX
    CPT Code   : URINE BACTERIA CULTURE 87088          XXX XX,XXXX
[5] Rx. Refills: UNSPECIFIED [NOT REQUIRED]
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
[9] Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
4	Verify that the Form Type is CMS-1500 and that the date of billing is entered. Make sure the Disch Stat field is populated. If all the data have been entered correctly, section 4 should display the correct revenue codes and costs. Press the **Return** to move to Screen 8.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/1500  SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 131              Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: UNSPECIFIED      Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED         Timeframe: ADMIT THRU DISCHARGE
    Charge Type : INSTITUTIONAL      Disch Stat:
    Form Type   : CMS-1500             Division: MONTGOMERY VAMC
[2] Sensitive?  : UNSPECIFIED                 Assignment: YES
[3] Bill From   : XXX XX,XXXX                   Bill To: XXX XX,XXXX
[4] OP Visits   : XXX XX,XXXX
[5] Rev. Code   : 306-LAB/BACT-MICRO     87088      $33.20  OUTPATIENT VISIT
    Rev. Code   : 307-GASTR-INST SVS     81001      $12.77  OUTPATIENT VISIT
    OFFSET      :       $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :   $45.97
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED


<RET> to CONTINUE, 1-7 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
5	From Screen 8, enter 3 to add a **Rendering** and **Referring** provider.
6	To edit, select Section 5 and enter the **CLIA** # if required by the payer.
	*After Patch IB*2.0*320, the billing software will automatically populate the CLIA# for the division on the claim when the claim is for the Service Type = 5 (Diagnostic Laboratory) if the CLIA# exists in the VistA Institution file. Users may override this value for the current claim only.*
	For outside laboratory services, the billing software will automatically populate the CLIA# if there is a Laboratory or Facility secondary ID defined for the outside facility with a ID Qualifier of X4 (CLIA #).
	There will be a Error Message for laboratory claims to Medicare when there is no CLIA# on the claim and a Warning Message for laboratory claims to other payers when there is no CLIA# on the claim.

```
IB,PATIENT3   000-00-0000   BILL#: K300XX - Outpat/1500  SCREEN<8>
================================================================================
                         BILLING - SPECIFIC INFORMATION
[1] Unable To Work From: UNSPECIFIED [NOT REQUIRED]
    Unable To Work To  : UNSPECIFIED [NOT REQUIRED]
[2] ICN/DCN(s)         : UNSPECIFIED [NOT REQUIRED]
    Tx Auth. Code(s)   : UNSPECIFIED [NOT REQUIRED]
[3] Providers          :
     - REFERRING (MD)  : IB,DOCTOR5     Taxonomy: XXXXXXXXXX (XX)
                                      [P]XX0000
     - RENDERING (MD)  : IB,DOCTOR4     Taxonomy: XXXXXXXXXX (XX)
                                      [P]XXX123
[4] Other Facility (VA/non): UNSPECIFIED [NOT REQUIRED]
    Lab CLIA #         : DXXXX000
    Mammography Cert # : UNSPECIFIED [NOT REQUIRED]
[5] Chiropractic Data  : UNSPECIFIED [NOT REQUIRED]
[6] Form Locator 19    : UNSPECIFIED [NOT REQUIRED]
[7] Billing Provider   : MONTGOMERY VAMC
    Taxonomy Code      : 282N00000X
[8] Force To Print?    : NO FORCED PRINT
[9] Provider ID Maint  : (Edit Provider ID information)
<RET> to CONTINUE, 1-6 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Note: There is a new field in Section 4 for the Mammography Certification Number where users can enter a certification number on claims for mammography exams. The known Mammography Certification Numbers will be stored in the Institution file, one per site.

6.6. Pharmacy Claims

1500 pharmacy claims can be submitted electronically to the clearinghouse where they will be printed and mailed.

The following screens give a simplified example of a pharmacy claim.

Step	Procedure
1	When processing a Pharmacy claim, information on Screens 1 and 2 should be reviewed for correctness. Press the **Return** key to move from one screen to the next.
2	On Screen 3, the payer information is reviewed for correctness. The patient may have more than one insurance policy. If the correct information is not displayed, select a section (1, 2, or 3) and edit the necessary fields. Press **Return** to continue to Screen 5. *For Pharmacy claims, change the form type to a CMS-1500.*

```
IB,PATIENT5    000-00-0000   BILL#: K303XX - Outpat/1500            SCREEN <3>
================================================================================
                              PAYER INFORMATION
[1] Rate Type  : REIMBURSABLE INS.           Form Type: CMS-1500
    Responsible: INSURER                     Payer Sequence: Primary
    Bill Payer : UNSPECIFIED                 Transmit: No-Ins. co transmit off

 Insurance   COB Subscriber ID     Group       Holder  Effectve  Expires   Only
 ===============================================================================
 BLUE CROSS   p  PPAXXXXXXXXX      13000       SPOUSE  01/01/00            IOrM
 MEDICARE(W      XXXXXXXXXA        PART A      SELF    11/01/96           *WNR*
 MEDICARE(W      XXXXXXXXXA        PART B      SELF    07/01/99           *WNR*

[2] Billing Provider Secondary IDs: UNSPECIFIED [NOT REQUIRED]

[3] Mailing Address :
    NO MAILING ADDRESS HAS BEEN SPECIFIED!   (Patient has Medicare)
    Send Bill to PAYER listed above.

<RET> to CONTINUE, 1-3 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
4	The highlighted fields are auto-populated. Remember that this is a professional bill that is being transmitting as a CMS-1500, so each HCPCS code will have to be associated with a diagnosis code. To begin this process, type **4** to edit the **Cod. Method** field and press the **Return** key.

```
IB,PATIENT5    000-00-0000   BILL#: K303XX - Outpat/1500            SCREEN <5>
================================================================================
                        EVENT - OUTPATIENT INFORMATION
<1> Event Date : XXX XX,XXXX
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1
[3] OP Visits  : UNSPECIFIED
[4] Cod. Method: HCPCS
    CPT Code   : Oral prescrip drug non chemo J8499       V68.1    XXX XX,XXXX
[5] Rx. Refills: WARFARIN SODIUM 5MG (COUMADIN) TAB               XXX XX,XXXX
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
5	At the **Select Procedure Date** field, re-type the date.
6	At the **Select Procedure** field, type the appropriate code. Once the code auto-populates the data, type **YES** to confirm.
7	At the **Provider** field, type the name of the physician. Information related to that provider will auto-populate.
8	Type the appropriate data related to the **Place of Service** and the **Type of Service**.
9	Press **Return** until Screen 5 appears.

```
<<CURRENT PROCEDURAL TERMINOLOGY CODES>>

LISTING FROM VISIT DATES WITH ASSOCIATED CPT CODES
IN OUTPT ENCOUNTERS FILE

================================================================================
NO.  CODE    SHORT NAME                CLINIC           DATE
================================================================================

NO CPT CODES ON FILE FOR THE VISIT DATES ON THIS BILL


PROCEDURE CODING METHOD: HCPCS (1500 COMMON PROCEDURE CODING SYSTEM)
         //
Select PROCEDURE DATE (X/XX/XX-XX/XX/XX): XX-XX-XX
* Patient has no Visits for this date...

   Select PROCEDURE: J
 Searching for a CPT,(pointed-to by PROCEDURES)
  J8499     Oral prescrip drug non chemo
        ...OK? Yes// Yes  Oral prescrip drug non chem  Rx: 0000000D
PROCEDURES: J8499//
Select CPT MODIFIER SEQUENCE:
PROVIDER: IB,DOCTOR6//
ASSOCIATED CLINIC: CARDIAC CONSULT
DIVISION: MONTGOMERY VAMC//        619
PLACE OF SERVICE: 22        OUTPATIENT HOSPITAL
TYPE OF SERVICE: 1        MEDICAL CARE
EMERGENCY PROCEDURE?: NO//   NO
PRINT ORDER:
```

Step	Procedure
10	Notice the association has been made between the diagnosis code and the required procedure code. Press **Return** to move to Screen #7.

```
IB,PATIENT5    000-00-0000   BILL#: K303XX - Outpat/1500          SCREEN <5>
================================================================================
                        EVENT - OUTPATIENT INFORMATION
<1> Event Date : XXX XX,XXXX
[2] Prin. Diag.: ISSUE REPEAT PRESCRIPT - V68.1
[3] OP Visits  : XXX XX,XXXX
[4] Cod. Method: HCPCS
    CPT Code   : Oral prescrip drug non chemo   J8499  V68.1  XXX XX,XXXX
[5] Rx. Refills: RANITIDINE HCL 150MG (ZANTAC) TAB            XXX XX,XXXX
[6] Pros. Items: UNSPECIFIED [NOT REQUIRED]
[7] Occ. Code  : UNSPECIFIED [NOT REQUIRED]
[8] Cond. Code : UNSPECIFIED [NOT REQUIRED]
<9> Value Code : UNSPECIFIED [NOT REQUIRED]

<RET> to CONTINUE, 1-9 to EDIT, '^N' for screen N, or '^' to QUIT:
```

Step	Procedure
11	There are no changes to this screen. Ensure the charges pulled up and the procedure code are associated with the diagnosis code. Press **Return** to move to Screen #8.

```
IB,PATIENT5    000-00-0000   BILL#: K303XX - Outpat/1500            SCREEN <7>
================================================================================
                          BILLING - GENERAL INFORMATION
[1] Bill Type   : 131             Loc. of Care: HOSPITAL - INPT OR OPT (INCLU
    Covered Days: UNSPECIFIED     Bill Classif: OUTPATIENT
    Non-Cov Days: UNSPECIFIED        Timeframe: ADMIT THRU DISCHARGE
    Charge Type : UNSPECIFIED       Disch Stat:
    Form Type   : CMS-1500            Division: MONTGOMERY VAMC
[2] Sensitive?  : UNSPECIFIED                  Assignment: YES
[3] Bill From   : XXX XX,XXXX                    Bill To: XXX XX,XXXX
[4] OP Visits   : UNSPECIFIED
[5] Rev. Code   : 253-WARFARIN SODIUM 5  J8499  1      $36.00  PRESCRIPTION
          OFFSET: $0.00   [NO OFFSET RECORDED]
    BILL TOTAL  :      $36.00
[6] Rate Sched  : (re-calculate charges)
[7] Prior Claims: UNSPECIFIED
```

Step	Procedure
12	At the **Select Function** field, type **3** for **Rendering**.
13	At the **Function Performed By** field, type the provider's name. VistA will identify that provider or return a list for selection. Once the proper provider is selected, at **OK?** prompt, type **YES**. The correct provider's information will auto-populate.

```
Select FUNCTION: 3  (3    RENDERING)
   FUNCTION PERFORMED BY: IB,DOCTOR6

     Searching for a VistA identified provider
  IB,PROVIDER6     IPB          PHYSICIAN
        ...OK? Yes//    (Yes)
  PERFORMED BY: IB,PROVIDER6//
  TAXONOMY: Allopathic and Osteopathic Physicians
        //
    Taxonomy X12 Code: 207RC0000X
    Prov Specialty On File: 06
  CREDENTIALS: MD//
Select FUNCTION:
```

This claim is now ready for authorization.

6.7. Printed Claims

Some claims should not be transmitted electronically and should be printed locally.

These include:

- Claims requiring clinical attachments such as progress notes;
- Professional claims containing more than the maximum number of 8 diagnosis codes;
- Professional claims containing more than the maximum number of diagnosis pointers (4);
- Institutional claims containing more than the maximum number of procedure codes (999);

- Professional claims containing more than the maximum number of procedure codes/line items (50);
- Institutional pharmacy claims; and
- Secondary claims to Medicare WNR (When Medicare WNR is NOT the primary insurance).

6.8. View/Resubmit Claims – Live or Test – Synonym: RCB

A new option View/Resubmit Claims – Live or Test has been added to the EDI menu. This option replaces: Resubmit a Bill; Resubmit a Batch of Bills and View/Resubmit Claims as Test. This option will provide the ability to resubmit claims as test claims for testing or production claims for payment.

Step	Procedure
1	At the **Select EDI Menu For Electronic Bills Option**, type **RCB** and press the **Return** key.
2	At the **Enter (C)laim, (B)atch or (L)ist:** prompt, press the **Return** key to accept the default of **List**.
3	At the **(A)ll payers or (S)elected Payers?** prompt, type **A** for All Payers.
	If you choose Selected payers, after you enter Blue Cross of CA, for example, you will be prompted to included all insurance companies with the same Electronic Billing ID. This will prevent you from having to enter every BC/BS company defined in your Insurance file.
4	At the **Run for (U)B-04, (C)MS-1500 or (B)OTH:** prompt, press the **Return** key to accept the default of Both.
	*The Date Range for the search for claims has been restricted to a **maximum of 90 days** to minimize the impact of the search on the system.*
5	At the **Start with Date Last Transmitted:** prompt, type **T-200** for this example.
6	At the **Date Last Transmitted:** prompt, press the **Return** key to accept the default of 12/1/04. This will return results for 90 days.
7	At the **Select Additional Limiting Criteria (optional):** prompt, press the **Return** key without selecting anything additional.

```
Select EDI Menu For Electronic Bills Option: RCB  View/Resubmit Claims-Live or Test

*** NOTE: 2 '^' ARE NEEDED TO ABORT THE OPTION (^^)
          1 '^' BRINGS YOU BACK TO THE PREVIOUS SELECTION PROMPT(^)

SELECT BY: (C)LAIM, (B)ATCH OR SEE A (L)IST TO PICK FROM?: LIST//
PAYER SELECTION:
Run for (A)ll Payers or (S)elected Payers?: SELECTED PAYERS// A  ALL PAYERS

BILL FORM TYPE SELECTION:
Run for (U)B-04, (C)MS-1500 or (B)OTH: BOTH//

LAST BATCH TRANSMIT DATE RANGE SELECTION:
Start with Date Last Transmitted: t-200  (SEP 02, 2004)
Go to Date Last Transmitted:(9/2/04-12/1/04): 1/1/05//   (JAN 01, 2005)

ADDITIONAL SORT SELECTION CRITERIA:

1 - MRA Secondary Only
2 - Primary Claims Only
3 - Secondary Claims Only
4 - Claims Sent to Print at Clearinghouse Only

Select Additional Limiting Criteria (optional):
```

Step	Procedure
8	At the **Would you like to include cancelled claims? No//**: prompt, enter **No**.
9	At the **Would you like to include claims Forced to Print at the Clearinghouse? No//** prompt, enter **No**.

Sort by Batch if you want to resubmit batches of claims or Current Payer if you want to resubmit a variety of individual claims.

10	At the **Sort By** prompt, enter **B** to override the default of Current Payer.
11	At the **DO YOU WANT A (R)EPORT OR A (S)CREEN LIST FORMAT?:** prompt, press the **Return** key to accept the default of Screen List.

```
Would you like to include cancelled claims? No//

Sort By: Current Payer// ??

Enter a code from the list.

     Select one of the following:

          1         Batch By Last Transmitted Date (Claims within a Batch)
          2         Current Payer (Insurance Company)

Sort By: Current Payer// Batch By Last Transmitted Date (Claims within a Batch)

Would you like to include claims Forced to Print at the Clearinghouse? No// No
DO YOU WANT A (R)EPORT OR A (S)CREEN LIST FORMAT?: SCREEN LIST//
```

The following screen is displayed:

```
PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@15:52:10          Page:    1 of 1215
** A claim may appear multiple times if transmitted more than once. **
** T = Test Claim ** R = Batch Rejected
>>># of Claims Selected: 0 (marked with *)


    Claim #     Form  Type   Seq  Status           Current Payer
    Batch: 6050011182  Date Last Transmitted: Nov 30, 2004
1   K500XXX     UB-04  OUTPT    P  PRNT/TX          UNITED HEALTHCARE
    Batch: 6050011183  Date Last Transmitted: Nov 30, 2004
2   K500XXX     UB-04  OUTPT    P  REQUEST MRA      MEDICARE (WNR)
    Batch: 6050011184  Date Last Transmitted: Nov 30, 2004
3   K500XXX     1500  OUTPT    P  PRNT/TX          UNITED HEALTHCARE
    Batch: 6050011185  Date Last Transmitted: Nov 30, 2004
4   K500XXX     1500  OUTPT    S  PRNT/TX          SOUTHWEST ADMINISTRATORS
    Batch: 6050011186  Date Last Transmitted: Nov 30, 2004
5   K500XXX     UB-04  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
    Batch: 6050011187  Date Last Transmitted: Nov 30, 2004
6   K500XXX     1500  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
+         Enter ?? for more actions                                    >>>
  Claim(s) Select/De select            View Claims Selected
  Batch Select/De select               Print Report
  Resubmit Claims                      Exit
Action: Next Screen//
```

Step	Procedure
12	At the **Action** prompt, type **B** to select batches of claims to resubmit as test or

'**C**' to select claims.

13 At the **Select EDI Transmission Batch Number:** prompt, enter the number of the desired batch.

You may repeat the above, entering as many batch numbers as you want.

```
PREVIOUSLY TRANSMITTED CLAIMS Mar 21, 2005@16:07:38          Page:    1 of 1215
** A claim may appear multiple times if transmitted more than once. **
>>># of Claims Selected: 1 (marked with *)


    Claim #      Form  Type   Seq  Status           Current Payer
    Batch: 6050011182  Date Last Transmitted: Nov 30, 2004
1  *K500YRJ     UB-04  OUTPT    P  PRNT/TX          UNITED HEALTHCARE
    Batch: 6050011183  Date Last Transmitted: Nov 30, 2004
2   K50092T     UB-04  OUTPT    P  REQUEST MRA      MEDICARE (WNR)
    Batch: 6050011184  Date Last Transmitted: Nov 30, 2004
3   K500YSF      1500  OUTPT    P  PRNT/TX          UNITED HEALTHCARE
    Batch: 6050011185  Date Last Transmitted: Nov 30, 2004
4   K500YSZ      1500  OUTPT    S  PRNT/TX          SOUTHWEST ADMINISTRATORS
    Batch: 6050011186  Date Last Transmitted: Nov 30, 2004
5   K500YUD     UB-04  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
    Batch: 6050011187  Date Last Transmitted: Nov 30, 2004
6   K500YUE      1500  OUTPT    P  PRNT/TX          AETNA US HEALTHCARE
+         Enter ?? for more actions                                    >>>
  Claim(s) Select/De select              View Claims Selected
  Batch Select/De select                 Print Report
  Resubmit Claims as TEST                Exit
Action: Next Screen//  b   Batch Select/De select
Select EDI TRANSMISSION BATCH BATCH NUMBER: 6050011183
```

Step	Procedure

14 When you have entered all of the batches you want, at the **ACTION** prompt, type '**R**' for **Resubmit Claims**.

15 At the **Resubmit Claims:** prompt, press the **Return** key to resubmit the claims for payment.

The system will inform you of the number of claims that will be resubmitted and whether or not they are being submitted for payment or testing.

16 At the **Are You Sure You Want To Continue?:** prompt, type **YES** to override the default.

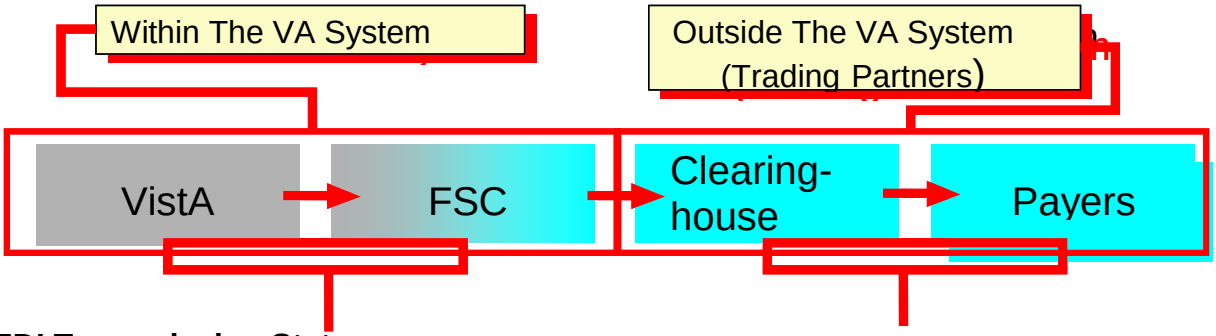
```
You are about to resubmit 2 claims as Production claims.
Are you sure you want to continue?: NO// y  YES
Resubmission in process ...
```

7. REPORTS

There are a number of reports available to monitor and manage electronic claims. The EDI menu option can be accessed from the Billing Clerk's Menu.

7.1. EDI Reports – Overview

TR reports provide the end-user with information to monitor and manage EDI claims still within the VA, that is, between the VAMC and the FSC in Austin, TX. The MM reports provide the end-user with information and feedback from parties external to the VA such as the clearinghouseand the various electronic payers.



TR- EDI Transmission Status

BAR	Bills Needing Resubmission Action
ECS	EDI Claim Status Report
MP	EDI Messages Not Yet Filed
PBT	Pending Batch Transmission Status Report
PND	EDI Batches Pending Receipt
REX	Ready for Extract Status Report
VPE	View/Print EDI Bill Extract Data

MM-EDI Return Message Management

EDI	Return Message Management Option Menu
CSA	Claim Status Awaiting Resolution
MCS	Multiple CSA Message Management
TCS	Test Claim EDI Transmission Report
	EDI Message Text to Screen Maint
	EDI Message Not Reviewed Report
	Electronic Error Report
	Electronic Report Disposition
	Return Message Filing Exceptions
	Status Message Management

7.2. Most Frequently Used Menus/Reports

7.2.1 Claims Status Awaiting Resolution – Synonym CSA

What is the purpose of this report?
Billing and accounts receivable staff use CSA to review the most current status messages and to perform follow-up actions on the bills. Electronic status messages, which include information and rejection messages from the clearinghouse or the payers, are accessed using this option.

When is this option used?
This is an option that must be checked **Daily** to determine which claims have rejection or warning messages that were returned from the clearinghouse™ or from payers. The cause for rejections must be resolved. This option should be used in conjunction with supporting reports (e.g. R022, R0SS, R0SC).

The CSA report contains a Primary, Secondary and Tertiary sort capability and can be sorted by:

A	Authorizing Biller
B	Bill Number
C	Current Balance
S	Date of Service
D	Division
E	Error Code Text
N	Number of Days Pending
M	Patient Name
P	Payer
R	Review in Process
L	SSN Last 4

Once the CSA screen list is displayed, users can select new sort criteria and **re-sort** the list without exiting the option.

Reports can be run showing rejections only (R) or both informational and rejection messages (B). Users most often run the CSA report to show rejections only so they can focus on those claims that require corrective action.

These messages are automatically assigned a status of **Not Reviewed** and require users to review them and make corrections to update this status in IB. Users select a bill from the list to view the details and the entire message text. Messages are marked as **reviewed** or **review in process**. Users may document comments.

*With Patch IB*2.0*320, changes were made to suppress the display of 2Q Claim Status Messages and duplicate claim status messages.*

As messages are reviewed they can be marked as follows:

- Not Reviewed – No action has been taken on a bill that has been returned from the clearinghouse/payer
- Review in Process – While a claim is being reworked, the status can be changed to "Review in Process"
- Review Complete – The error has been resolved and the message from this report will be cleared

Actions such as Cancel Bill, Copy/Cancel Bill, TPJI and Print Bill are available to the user via this option and the user can make needed corrections and re-submit claims from within this option.

Other options available on the CSA include:

- CSA-EDI History Display - The EDI History display option shows all the status messages under the selected bill/message. This information is similar to information that can be viewed under the TPJI menu options.
- CSA-Enter/Edit Comments - The enter/edit comments option gives the user the ability to add a comment onto a bill (status message) in order to inform AR and billing why the issue hasn't been resolved or why the claim was printed to paper.
- CSA-Resubmit by Print - The Resubmit by Print action is used when the user reviews the status message or bill and determines the only way to correct the problem is to submit the claim on hard copy as it cannot pass the electronic edits. The user may "resubmit by print" to the payer instead of retransmitting electronically. If printed from this option, users will be asked if they wish to "review complete" the status message, which will automatically clear it from the report.
- CSA-Retransmit a Bill - Similar to the Resubmit by Print action, the Retransmit Bill is used when the user reviews the status message or bill and determines the reason for the rejection has been corrected elsewhere in the system and the claim just needs to be resent. The user may then retransmit to the payer.
- CSA-Review Status - A bill will continue to show up on the report until it is cancel/cloned, canceled or the status is changed to Review Complete.

Users also have access to the option Multiple CSA Message Management from within the CSA list if they hold the IB Message Management security key.

7.2.2 Multiple CSA Message Management – Synonym: MCS

What is the purpose of this option?

This option is designed to allow users to take action on CSA messages when a problem arises during the processing of electronic claims that causes a large volume of erroneous status messages to be sent to the site. This option performs tasks similar to the CSA option.

*This option is locked by the **IB Message Management** security key.*

When is this option used?
This option is used when there are pages of erroneous messages in CSA that were caused by a processing problem. Use this option to take a similar action (such as retransmission of the associated claims) on multiple claims at the same time.

The initial search for claims and claims status messages is done automatically when the option is selected. The initial search results in the display of all claims that are **Not Cancelled** and for which the review status is **Not Reviewed** or **Review in Process**.

*If someone else is working on a claim in CSA, it will not display in MCS. Only one user can be in MCS at a time. The following message will be displayed: **Sorry, another user is currently using the MCS option. Please try again later.***

Once the initial list has been built, users may further refine their search or work from the default list.

The purpose of MCS is to select multiple claims and then apply the same action to all the selected claims. For example, users can enter a comment once and then apply the comment to 1-n claims.

Other actions available on the MCS include:
- Message Search – Allows the user to change the criteria upon which the list of claims will be built
- Change Review Status – Same as CSA
- Cancel Claims – Same as CSA
- Enter Comment – Same as CSA
- Resubmit by Print – Same as CSA
- Retransmit Bill – Same as CSA
- Select/Deselect Claims – Allows users to select the claims to which they want to apply an action

When using the Resubmit by Print action, the claims selected will not be removed from the list of claims until the claims have actually been printed.

7.2.3 Electronic Report Disposition

What is the purpose of this option?
This option allows the site to determine which clearinghouse generated electronic messages/reports are to be sent to the EDI mail group and which should be ignored.

When is this option used?

The default setting on this report will contain a disposition of "Mail Report to Mail Group". It is up to the individual site's supervisory staff to determine what reports should be ignored.

Further explanations of these reports are available in documents provided by the clearinghouse™. They are entitled Claim Submitter Reports – Providers Reference Guide. The guides are available at http://www.emdeon.com/VendorPartners/vendorpartners.php

The following reports should be reviewed when they are received. They contain information that cannot be translated into claim status messages therefore, this information is not available in CSA.

R000 NETWORK NEWS
Provides news on system problems, updates and other pertinent information.

RPT-02 FILE STATUS REPORT
Provides an initial analysis of the file by displaying file status of accepted or rejected and a description of the status. It also indicates the total number of claims and the dollar value if the file contains valid claims.

RPT-03 FILE SUMMARY REPORT
Provides summarized information on the quantity of accepted, rejected, and pending claims, as well as the total number of claims received by the clearinghouse for each submitted file.

RPT-08 PROVIDER MONTHLY SUMMARY
Displays the number and dollar value of claims accepted and forwarded by the clearinghouse for the month. Monthly and Y-T-D Totals for both accepted and rejected claims are included as well as the provider's top 25 errors for the month.

The following reports contain information that is also translated into status messages and displayed on CSA.

RPT-04 FILE DETAIL SUMMARY REPORT
Contains a detail summary of the file submitted for processing. It provides a file roll-up listing of all accepted, rejected, and pending claims contained in each file submitted to the clearinghouse. It also contains payer name/id and status of claim.

RPT-04A AMENDED FILE DETAIL SUMMARY REPORT
Contains a detailed listing of all claims for which the status was amended during the previous processing day. Claims statuses are amended when a pending claim is processed and/or a claim is reprocessed at the clearinghouse.

RPT-05 BATCH & CLAIM LEVEL REJECTION REPORT

Contains rejected batches and claims listed with detailed error explanations. In order to prevent “lost” claims, the RPT-05 report must be reviewed and worked after each file transmission.

RPT-05A AMENDED BATCH & CLAIM LEVEL REJECTION REPORT
Contains rejected batches and claims listed with detailed error explanations. In order to prevent “lost” claims, the RPT-05A report must be reviewed and worked after each file transmission.

RPT-10 PROVIDER CLAIM STATUS
This report contains information provided from payers who are receiving claims for adjudication from the clearinghouse. Not all payers who process claims through the the clearinghouse system provide information for this Provider Claim Status Report and the amount/frequency of information produced will vary from payer to payer.

RPT-11 SPECIAL HANDLING/UNPROCESSED CLAIMS REPORT
This report contains information provided from payers who are receiving claims for adjudication from the clearinghouse. Not all payers who process claims through the the clearinghouse system provide information for this Provider Claim Status Report and the amount/frequency of information produced will vary from payer to payer. The RPT-11 returns Unprocessed, Request for Additional Information, and Rejected statuses only.

7.2.4 EDI Claim Status Report- Synonym: ECS

What is the purpose of this report?
View electronic transmission status to assure claims move through the system in a timely fashion.

When is this option used?
It is recommended that initially this report be viewed daily as it provides transmission status of all claims that were transmitted to FSC Austin. Once a comfort zone is established and everything is flowing correctly, this report may only need to be run monthly.

Reports can be created based on:
- Specific Claim or Search Criteria
- Division
- Payer
- Transmission Date range
- EDI Status

Reports can be sorted by:
- Transmission Date
- Payer
- EDI Status
- Current Balance
- Division
- Claim Number
- AR Status
- Age

Possible EDI claim statuses include:
- Ready for Extract
- Pending Austin Receipt
- Accepted by Non-Payer
- Accepted Payer
- Error Condition
- Cancelled
- Corrected/Retransmitted
- Closed

7.3. Additional Reports and Options

7.3.1 Ready for Extract Status Report - Synonym: REX

What is the purpose of this report?

This report provides a list of claims held in a Ready for Extract status. These claims are held in a queue until batching occurs.

When is this option used?
Initially this option is used to assure claims are being transmitted at the times set in the MCCR Site Parameters. This option should by reviewed daily until there is a comfort level with the transmission timeframes and then less frequently based on local experience.

Claims that are trapped due to the EDI parameters being turned off can also be viewed. It is rare that EDI is turned off during processing. If this occurs, use EXT Extract Status Management to Cancel or Cancel/Clone/Auth the trapped claims.

Choices to view are:

1 All bills in Ready for Extract status
2 Bills trapped due to EDI parameter being turned off
(If EDI is on, no bills will be trapped in extract)

7.3.2 Transmit EDI Bills – Manual - Synonym: SEND

What is the purpose of this option?
This option is used to by-pass the normal daily/nightly transmissions queues if the need arises to get the claim to the payer quickly.

When is this option used?
There are occasions when there is a need to transmit a claim(s) immediately instead of waiting for the batching frequency as scheduled in the MCCR Site Parameter. This option will allow sending individual claim(s) or all claims in a ready for extract status.

Select one of the following:

A Transmit (A)LL bills in READY FOR EXTRACT status
S Transmit only (S)ELECTED bills

7.3.3 EDI Return Message Management Menu – Synonym: MM

This menu contains the options needed to define the types of electronic reports from the clearinghouse that the site needs to see and defines the text that should/should not allow automatic review and filing for informational status messages. It also contains an option to purge old status messages, reports for maintaining the integrity of the return message subsystem and the option for reviewing electronically returned messages.

7.3.4 EDI Message Text to Screen Maintenance

What is the purpose of this option?
This option controls what status and/or error messages users may wish to review using special text words and/or phrases. This will either require the message to be reviewed or it will auto-file the message and flag it as not needing a review.

This option allows for the display of a list of words or phrases that, if found in the text of an informational status message, will either always require the message to be reviewed or will auto-file the message and flag it as not needing a review.

When is this option used?
Depending on what types of status messages users wish to review for follow-up on rejected claims and/or monitoring claims status, users may want to add or edit additional text as needed.

The words and phrases for "Requiring Review" and "Not Requiring Review" will initially populate as shown in the screen print below. This option is used to edit or add more words or phrases, as required, to manage and control the status messages.

7.3.5 EDI Messages Not Reviewed Report

What is the purpose of this report?
This option allows for the display of all EDI return messages that were filed without needing a review based on the text entries in the message screen text file.

When is this option used?
The report can be run for a user-selected date range, based on the date the message was received at the site, and may be sorted by the message text that caused the message to not need a review or by the bill number. Users may want to use this option for analysis or review of all EDI messages that they were not able to view initially.

7.3.6 Electronic Error Report

What is the purpose of this report?
This report provides a tool for billing supervisors and staff to identify the "who, what, and where" of errors in the electronic billing process. This is a report that will allow the supervisory staff to review "frequently received" errors. This is an informational management tool requiring no actions on the part of the billing staff.

When is this option used?
This option can be used at any time by a supervisor or other management staff when they want to determine the reason for various errors (i.e., the same error being made by one or more of the billing staff). The report can be sorted by:

A AUTHORIZING BILLER
B BILLED AMOUNT
E EPISODE OF CARE
P PATIENT NAME
S PATIENT SSN
Y PAYER NAME
C ERROR CODE

7.3.7 Return Messages Filing Exceptions

What is the purpose of this option?
After users have transmitted claims and they have been received for EDI processing, a message will be sent to the mail groups shown in the set-up section of this manual.

When is this option used?
When a message is sent, it is temporarily stored in the "EDI MESSAGES" file. Normally, these messages are in and out of this file in a matter of seconds. If, however, a problem is detected and a message cannot be filed in the appropriate file (s) for its message type, the message will remain in this temporary file.
There are two (2) ***statuses*** for messages in this file.

- **Pending**: The task to force a message to update the IB files has either not yet been created or has been created, but has not yet begun to run.
- **Updating**: The task to force a message to update the IB files has started. It may or may not still be running. If you try to file a message with this status, a check is made to see if it is currently running. If it is, the message will not be re-tasked.

Any message may be viewed or printed. This does not affect the message in any way, but looking at the message may help to indicate the next course of action needed.

There are two (2) ***actions*** available to get these messages out of the file.

- **File Message**: This action re-executes the tasked job to update the database with the contents of the message.
- **Delete Message**: This is a drastic action that should only be taken when it has been determined there is no other possible way to process a message. When a message is deleted using this action, a bulletin is sent to the IB EDI Mail Group with the text of the message and the name of the user who deleted the message. Users must hold the IB SUPERVISOR security key to perform this action.

7.3.8 Status Message Management

What is the purpose of this option?
This option allows users to print/purge electronically returned status messages that have been in a final review status for a user-selected number of days.

When is this option used?
There will be an accumulation of status messages in a final review status. This option will delete or purge status messages in one of the Final Review statuses prior to a selected date. Auto purging of messages can also be set in the IB Site Parameters.

This report can be sorted by:
A ALL STATUS MESSAGES
S SELECTED STATUS MESSAGES

Selected status message reports can be run showing:

A Auto Filed/No Review Only
B Bill Number
S Message Severity
T Specific Message Text

7.3.9 Bills Awaiting Resubmission – Synonym: BAR

What is the purpose of this report?
This report lists all batches that have been resubmitted but which did not include all of the bills from the original batch. These are batches that have at least one bill still not resubmitted or canceled.

When is this option used?
When a batch is identified to have a claim in error, the batch may be re-submitted with the claim in error removed. This option will track and report specific bills in this category. The report can sort data by:

B BILL NUMBER
L LAST SENT DATE
A BILLED AMOUNT
N BATCH NUMBER (LAST SENT IN)

The report will also indicate the “Bill Transmission Status”.

7.3.10 EDI Messages Not Yet Filed –Synonym: MP

What is the purpose of this report?
This report allows you to select receipt, rejection or both message types and a minimum number of days these messages have been in a PENDING or UPDATING status before they will be included on the report. The report will then list all messages in the file that meet these criteria.

When is this option used?
This is a status report that allows for review of messages not yet filed.

7.3.11 Pending Batch Transmission Status Report – Synonym: PBT

What is the purpose of this report?
This report shows the current transmission status of a batch's mail message. It also includes the mail message number; the first and last date/time it was sent. Only batches in a pending transmission status will be on this report.

When is this option used?
This is another option to track the batch(s) of claims after authorizing and transmission to be sure all batches transmitted have been received in Austin. Users can omit both the station number prefix at the front of the batch number and the following zeroes and use only the final digits of the batch number for lookup.

7.3.12 EDI Batches Pending Receipt– Synonym: PND

What is the purpose of this report?
This report lists all batches by batch number that have been in a PENDING status and have not yet received confirmation of receipt from Austin for more than one (1) day. The report includes individual claims if the users choose to include them.

The report includes:
- Batch Number
- Transmission Date
- Mail Message #

Claims display the following:
- Claim Number
- Payer Sequence
- Balance Due
- EDI Status
- IB Status
- AR Status

```
EDI Batches Pending Austin Receipt After 1 Day                          Page: 2
Run Date: 01/07/2008@14:44:28

  Batch #       Transmission Date         Mail Message #
 ------------------------------------------------------------------------------

     Claim    Seq     Bal Due   EDI Stat   IB Status     AR Status
     K600KQD   P       198.54      P       PRNT/TX       NEW BILL
     K600NEU   P        76.36      P       PRNT/TX       NEW BILL
     K600QR2   P       305.11      P       PRNT/TX       NEW BILL
     K600WS7   P        76.36      P       PRNT/TX       NEW BILL
     K600WSF   P       880.71      P       PRNT/TX       NEW BILL

  4420029590    03/29/2006@21:05:33       1321

     Claim    Seq     Bal Due   EDI Stat   IB Status     AR Status
     K600FN7   P        76.36      P       REQUEST MRA   BILL INCOMPLETE
     K600IPF   P        73.01      P       REQUEST MRA   BILL INCOMPLETE
     K600WSA   P      4390.06      P       REQUEST MRA   BILL INCOMPLETE
     K600WSK   P        73.01      P       REQUEST MRA   BILL INCOMPLETE

Enter RETURN to continue or '^' to exit:
```

Members of the G.IB EDI mail group will receive an email message when there are batches of claims that have not received a confirmation message from Austin after 1 day.

```
Subj: EDI BATCHES WAITING AUSTIN RECEIPT FOR OVER 1 DAY  [#21387]
06/19/04@19:02  6 lines
From: XXXXXXXXXXX,XXXX X  In 'IN' basket.   Page 1  *New*
-------------------------------------------------------------------------------
There are 30 EDI batch(es) still pending Austin receipt
for more than 1 day.  Please investigate why they have not yet been confirmed
as being received by Austin.

Since there were more than 10 batches found, please run the
  EDI BATCHES WAITING FOR AUSTIN RECEIPT OVER 1-DAY report to get a list of the
se batches.

Enter message action (in IN basket): Delete//
```

When is this option used?
Users may use this option to obtain Batch or Messages numbers when a problem arises or to monitor the status of batches recently transmitted. Batches should not be in a "Pending Austin Receipt" status for more than a day.


***Contact IRM** for assistance in finding out why a confirmation message has not been received from Austin.*


*Before contacting IRM, note the **Message Numbers** for the batches that you need investigated. These numbers can be found in the **PND** option.*


*If IRM needs assistance, log a **REMEDY ticket** or call the **National Help Desk at 1-888-596-4357.***

7.3.13 View/Print EDI Bill Extract Data – Synonym: VPE

What is the purpose of this option?
This option will display the EDI extract data for a bill.

When is this option used?
This option is used only if there is a need to determine what data was transmitted for a specific bill. The detailed extract data will contain all the elements in the flat file that is transmitted to FSC Austin. FSC Austin, in turn, translates the data to a HIPAA-compliant format for transmission to the clearinghouse™.

7.3.14 Insurance Company EDI Parameter Report – Synonym: EPR

What is the purpose of this option?
This option will display the EDI Parameters of the Active Insurance Companies defined in Vista.

The contents of the following parameters will be included in this report:

- Insurance Company Name
- Street Address and City of Insurance Company
- Electronic Transmit?
- Institutional Electronic Bill ID

- Professional Electronic Bill ID
- Electronic Type
- Type of Coverage
- Always Use main VAMC as Billing Provider

```
All Companies            Insurance Company EDI Parameter Report                        Page: 1
Sorted By Ins Company Name
Mar 21, 2005@14:03:32
Only Blank or 'PRNT' Bill ID's = NO                                                     VAMC
                                                Electron  Inst  Prof Electronic          Bill
Insurance Company Name  Street Address  City    Transmit   ID    ID  Type        Type of… Prov
=======================================================================================================
AETNA LIFE INSURANCE    741.. STREET    …,CA    YES-LIVE  XXXXX     Commercial   Health…  BOTH
```

When is this option used?
This option can be used whenever there is a need to confirm that the Insurance Company parameters are correctly defined to support the electronic transmission of claims. This option will be of value when the eClaims Plus patches are loaded and sites gain the ability to transmit secondary claims to the payers (electronic, end-to-end processing). For example, sites can use this option to make sure the payers' Electronic Bill IDs are defined.

7.3.15 Test Claim EDI Transmission Report - TCS

What is the purpose of this option?
The Claim Status Messages for claim(s) and batch(es) submitted via the RCB option as Test claims will not appear in CSA. No action will be required in response to these messages. For informational purposes, these messages will be available through the Test Claim EDI Transmission Report. This option can be used to investigate the status of test claims to see, for example, whether the transmission was accepted/rejected by FSC or accepted/rejected by the clearinghouse™.

The messages in this option will be automatically purged after 60 days.

When is this option used?
This option can be used whenever a user needs to investigate the current status of a claim or batch of claims. The messages in this report will be like the messages in TPJI.

```
Test Claim EDI Transmission Report                                          Page: 1
Selected Batches                                                Mar 22, 2005@12:14:38
================================================================================

Batch#:  6050011719
Claim#:  K404XXX    IB,Patient7      (1500, Prof, Outpat)
--------------------------------------------------------------------------------
Transmission Information
 03/17/2005@11:11:25  Bch#11719  IB,Clerk2   CIGNA HEALTHCARE  (S)
```

7.3.16 Third Party Joint Inquiry – Synonym: TPJI

What is the purpose of this option?
This option provides a convenient location for both claim, AR, Insurance and EDI data related to a claim.

When is this option used?
This option is used by both Integrated Billing and Accounts Receivable personnel who require information about a claim. Both AR and IB users can also add comments to an MRA Request or non-MRA Request claim using this option.

The following actions are available from TPJI

BC	Bill Charges
DX	Bill Diagnosis
PR	Bill Procedures
CB	Change Bill
ED	EDI Status
AR	Account Profile
CM	Comment History
IR	Insurance Reviews
HS	Health Summary
AL	Active List
VI	Insurance Company
VP	Policy
AB	Annual Benefits
EL	Patient Eligibility

*Patch IB*2*377 included changes to allow the addition of and the viewing of MRA Request claim comments using TPJI. Comment History now pertains to MRA Request claims as well as regular claims. MRA Request claim comments are not stored as AR comments though.*

7.3.17 Patient Billing Inquiry – Synonym: INQU

What is the purpose of this option?
This option provides some basic information about a particular claim. It is a simple inquiry option.

When is this option used?
This option can be used to view the following type of information related to a bill:

- Bill Status
- Rate Type
- Form Type
- Visit Date(s)
- Charges
- AR Status
- Statement Dates
- Dates related to actions such as Entered, Cancelled or Printed

- Bill Number copied from or to
- Patient, Mailing and Insurance Company address

The data available varies based upon when the inquiry is made and what actions have been carried out regarding the claim.

8. APPENDIX A – BATCH PROCESSING SETUP

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BATCH PROCESSING SETUP

The following example shows you how to define batch processing for a payer:

Step	Procedure
1	Under the IB Site Parameters, go to **field [15] EDI/MRA Activated**.
2	Edit fields as necessary (fields are highlighted in yellow for this example).

Details on each field follow the screen example.

*When the MRA software was loaded (Patch IB*2.0*155), the **EDI/MRA Activated** field was removed from this screen. Only **IRM** is able to access this field via **Fileman**. The reason for this is to prevent MRA from being activated before the FSC is ready to accept MRA transmissions from a particular site.*

```
IB Site Parameters            Aug 13, 2003@10:22:46          Page:    5 of 6
Only authorized persons may edit this data.
+---------------------------------------------------------------------------

[15] EDI/MRA Activated               : EDI

     EDI Contact Phone               :

     EDI 837 Live Transmit Queue     : MCH

     EDI 837 Test Transmit Queue     : MCT

     Auto-Txmt Bill Frequency        : Every Day

     Hours To Auto-Transmit          : 1300;1600

     Max # Bills Per Batch           : 50

     Only Allow 1 Ins Co/Claim Batch?: NO

     Last Auto-Txmt Run Date         : 08/13/03

     Days To Wait To Purge Msgs      : 120
```

EDI/MRA Activated: Controls whether EDI is available for the site. Choose from:

0 - NOT EDI OR MRA;
1 - EDI ONLY;
2 – MRA ONLY; or
3 – BOTH EDI AND MRA

You will have to reset this to **3** when you want to activate **MRA.**

Following the installation of MRA, there will be additional fields that you must define.

```
IB Site Parameters            May 27, 2004@14:14:24          Page:    5 of    6
Only authorized persons may edit this data.
+
      HMO NUMBER                    :
      STATE INDUSTRIAL ACCIDENT PROV:
      LOCATION NUMBER               :

[15] EDI/MRA Activated               : BOTH EDI AND MRA
     EDI Contact Phone               : 217-554-3135
     EDI 837 Live Transmit Queue     : MCH
     EDI 837 Test Transmit Queue     : MCT
     Auto-Txmt Bill Frequency        : Every Day
     Hours To Auto-Transmit          : 1000;1400;2000
     Max # Bills Per Batch           : 10
     Only Allow 1 Ins Co/Claim Batch?: NO
     Last Auto-Txmt Run Date         : 05/26/04
     Days To Wait To Purge Msgs      : 45
     Allow MRA Processing?           : YES
     Enable Automatic MRA Processing?: YES

+         Enter ?? for more actions
EP  Edit Set                                        EX  Exit Action
```

EDI Contact Phone: The phone number of the person at the site contact to whom EDI inquiries will be directed. The Pay-to Provider telephone number that is defined in Section 10 for each Pay-to Provider, will be printed on the UB04 and CMS-1500 form starting with Patch IB*2.0*400.

EDI 837 Live Transmit Queue: The name of the Austin data queue that will receive claims to be processed via a live connection to the clearinghouse. These data are populated at the time of installation and would not normally be edited by the site.

EDI 837 Test Transmit Queue: The name of the Austin data queue that will receive test claims. These data are populated at the time of installation and would not normally be edited by the site.

Auto Transmit Bill Frequency: The desired number of days between each execution of the automated bill transmitter. For example, if the automated bill transmitter should run only once a week, this number would be 7. If the automated bill transmitter should run every night, then the number should be 1. If this is left blank or zero then the automated bill transmitter background job will never run.

Hours To Transmit Bills: Contains the times of the day when EDI transmission of bills should occur. A maximum of 4 daily times daily may be entered and the times must be separated by a semi-colon. Times must be entered in 4-digit military format, without punctuation (HHMM;HHMM;HHMM;HHMM). If no times are entered, EDI transmission will take place as a normal part of the nightly job.

Max # Of Bills In A Batch: The maximum number of bills allowed in a single batch. With a new payer, it is suggested that you begin with fairly small batches (10-20 claims).

Only Allow 1 Ins Co/Claim Batch: Indicates whether or not the site wishes to limit batches to claims for a single insurance company.

Last Auto-Txmt Run Date: The last date the auto transmit of bills was run at the site. These data are display only and cannot be edited.

Days To Wait To Purge Msgs: This is the number of days after an electronic status message has been marked reviewed, that the purge message option can delete it from the system.

9. APPENDIX B – GLOSSARY

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GLOSSARY OF TERMS

835	The HIPAA adopted standard for electronic remittance advice to report the processing of all claim types (including retail pharmacy). The 835 is sent from health plans to health care providers and contains detailed information about the processing of the claim. This includes payment information and reduction or rejection reasons. The 835 transactions generally contain information about multiple claims. All health plans are required to use the same explanation of benefit codes (adjustment reason codes) and adhere to very specific reporting requirements. The term “835” is used interchangeably with electronic remittance advice.
837	The HIPAA adopted standard for electronic submission of hospital, professional and dental claims or encounters. The 837 is sent from health care providers to health plans (payers). The 837 transactions are generally multiple claims (batches). The 837 standard includes the information for coordination of benefits and is also used for secondary payer claims submission. The term “837” is used interchangeably with electronic claim.
Billing Provider Secondary ID Number	This is either the facility tax ID # (default) or an ID assigned to the facility by the insurance company.
Care Unit	Specific data related to patient care (pre-defined by an insurance company) that provides the insurance company with a finer breakdown of the care being billed. The data that comprises the breakdown are insurance company specific and are not required by all payers. (For example, Orthopedics, Dermatology, Urology, etc.)
Claim Status Message	Electronic messages returned to the VAMC providing status an information on a claim from the Financial Service Center (FSC), the clearinghouse or a payer.
Clearinghouse	A company that provides batch and real-time transaction processing services. Transactions include insurance eligibility verification, claims submission process and electronic remittance information and payment posting for electronic claims.
CSA	Claims Status Awaiting Resolution Used to reference the option used by billing staff to review the most current status messages received for a bill(s) and do follow-up on the bills. Users will be able to select a bill from the list to view the details and the entire message text as well as to

	mark the message as reviewed or under review and document user comments.
eClaim	A claim that is submitted electronically from the VA.
EDI	Electronic Data Interchange. Electronic Data Interchange (EDI) is the process of transacting business electronically. It includes submitting claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility.
Electronic Payer	A payer that has an electronic connection with the clearinghouse.
ePayer	Payer that accepts electronic claim from the clearinghouse pays electronically. See Payer.
Facility Fed Tax ID #	This is the number that will be the default for all providers for the ID type at the facility if the payer does not have specific requirements.
Fiscal Intermediary	A fiscal intermediary performs services on behalf of health care payers. These services include claim adjudication, reimbursement and collections. Trailblazer is an example of a fiscal intermediary that acts on behalf of Medicare. Trailblazer receives claims from the VA in the form of an 837 file and then adjudicates the claims to create a MRA/EOB 835 file.
Form Types	The UB-04 or CMS-1500 billing form on which services will be billed.
FSC	The VA Financial Services Center in Austin. The Financial Service Center translates claims into an industry-standard format (HIPAA 837) and forwards claims to the clearinghouse. The FSC is the single point for the exchange of data between VistA and the clearinghouse
Healthcare Company	See Payer.
HIPAA	Health Insurance Portability and Accountability Act. Health Insurance Portability and Accountability Act. In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health

	care data between health care payers, plans, and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards thus eliminating all non-standard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.
Insurance Company	See Payer.
Legacy IDs	This term refers to those payer-provided or users own IDs (individual and organizational) which will eventually be made obsolete by the use of National Provider Identifiers.
LPS (formerly EPS)	Legacy Product Support
Non-VA Facility	Any facility that provides services to a VA patient and subsequently bills the VA for those services.
Non-VA Provider	Any individual provider who provides services to a VA patient and subsequently bills the VA for these services
National Provider Identifier	A standard, unique health identifier for health care providers, both individuals and organizations
Parent	The top facility in a hierarchical domain.
Payer	The insured's insurance company. Other terms that are used to denote Payer include, ePayer, insurance company, healthcare company, etc.
Payer Code	A code used for enrollment that uniquely identifies the payer.
Payer List	List of payers that consist of the payer category, claim type, payer code, and payer name.
Provider	Provider of health care services.
Provider ID	A provider ID can represent a facility or an individual physician/provider.
Taxonomy Code	The Health Care Provider Taxonomy code set is a collection of unique alphanumeric codes, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization. The Health Care Provider Taxonomy code set allows a single provider (individual, group, or institution) to identify their specialty category.
UPIN	Unique Provider Identification Number.

URL	Uniform Resource Locator.
VAMC	Veterans Affairs Medical Center.
VISN	Veterans Integrated Service Network.

10. APPENDIX C –HIPAA PROVIDER ID –REFERENCE GUIDE

APPENDIX C –HIPAA Provider ID –Reference Guide

This table displays the HIPAA qualifiers and associated ID types. This table can be used to help identify what type of Provider ID type is being used in the electronic format.

Institutional										
Qualifier		Billing Provider	Attending		Operating		Other		Service	
	Definition	2010AA	2310A	2330D	2310B	2330E	2310C	2330F	2310E	2330H
			C	O	C	O	C	O	C	O
		PRV1	OPR2	OP1	OPR3	OP2	OPR4	OP9	SUB2	OP3
OB	State License Number	-	OB		OB		OB		OB	
1A	Blue Cross Provider Number	1A	1A	1A	1A	1A	1A	1A	1A	-
1B	Blue Shield Provider Number	-	1B	1B	1B	1B	1B	1B	1B	1B
1C	Medicare Provider Number	1C	1C	1C	1C	1C	1C	1C	1C	1C
1D	Medicare Provider Number	1D	1D	1D	1D	1D	1D	1D	1D	1D
1G	Provider UPIN Number	1G	1G	1G	1G	1G	1G	1G	1G	-
1H	TRICARE ID Number	1H	1H	1H	1H	1H	1H	1H	1H	-
1J	Facility ID Number	1J	-	-	-	-	-	-	1J	-
B3	PPO Number	B3	-	-	-	-	-	-	-	-
BQ	HMO Code Number	BQ	-	-	-	-	-	-	-	-
EI	Employer's ID Number	EI	EI	EI	EI	EI	EI	EI	EI	EI
FH	Clinic Number	FH	-	-	-	-	-	-	FH	-
G2	Provider Commercial Number	G2	G2	G2	G2	G2	G2	G2	G2	G2
G5	Provider Site Number	G5	-	-	-	-	-	-	G5	-
LU	Location Number	LU	LU	LU	LU	LU	LU	LU	LU	LU
N5	Provider Plan Network ID Number	-	N5	N5	N5	N5	N5	N5	N5	N5
TJ	Federal Taxpayer's ID Number	-		-	-	-	-	-	-	-
X4	Clinical Lab Improvement Amendment (CLIA #)	-	-	-	-	-	-	-	-	-
U3	Unique Supplier ID Number (USIN)	-	-	-	-	-	-	-	-	-
SY	Social Security Number	SY	SY	-	SY	-	SY	-	-	-
X5	State Industrial Accident Provider Number	X5	X5	-	X5	-	X5	-	X5	-
C = Current Payer O = Other Payer										

Professional												
Qualifier		Billing Provider	Referring		Rendering		Purchased		Service Facility		Supervising	
	HIPAA Loop	2010AA	2310A	2330 D	2310B	2330 E	2310 C	2330 F	2310 D	2330 G	2310 E	2330 H
			C	O	C	O	C	O	C	O	C	O
	VPE Record	PRV1	OPR5	OP4	OPR2	OP1	SUB1	OP6	SUB2	OP7	OPR8	OP8
OB	State License Number	-	OB	-	OB	-	OB	-	OB	-	OB	-
1A	Blue Cross Provider Number	-	-	-	-	-	1A	-	1A	-	-	-
1B	Blue Shield Provider Number	1B	1B	1B	1B	1B	1B	1B	1B	1B	1B	1B
1C	Medicare Provider Number	1C	1C	1C	1C	1C	1C	1C	1C	1C	1C	1C
1D	Medicare Provider Number	1D	1D	-	1D	-	1D	1D	1D	1D	1D	1D
1G	Provider UPIN Number	1G	1G	-	1G	-	1G	-	1G	-	1G	-
1H	TRICARE ID Number	1H	1H	-	1H	-	1H	-	1H	-	1H	-
1J	Facility ID Number	1J	-	-	-	-	-	-	-	-	-	-
B3	PPO Number	B3	-	-	-	-	-	-	-	-	-	-
BQ	HMO Code Number	BQ	-	-	-	-	-	-	-	-	-	-
EI	Employer's ID Number	EI	EI	EI	EI	EI	EI	EI	-	-	EI	EI
FH	Clinic Number	FH	-	-	-	-	-	-	-	-	-	-
G2	Provider Commercial Number	G2	G2	G2	G2	G2	G2	G2	G2	G2	G2	G2
G5	Provider Site Number	G5	-	-	-	-	-	-	-	-	-	-
LU	Location Number	LU	LU	LU	LU	LU	LU	LU	LU	LU	LU	-
N5	Provider Plan Network ID Number	-	N5	N5	N5	N5	N5	N5	-	N5	N5	N5
TJ	Federal Taxpayer's ID Number	-	-	-	-	-		-	TJ	-	-	-
X4	Clinical Lab Improvement Amendment (CLIA #)	-	-	-	-	-		-	X4	-	-	-
U3	Unique Supplier ID Number (USIN)	U3	-	-	-	-	U3	-	-	-	-	-
SY	Social Security Number	SY	SY		SY		SY	-	-	-	SY	-
X5	State Industrial Accident Provider Number	X5	X5	-	X5	-	X5	-	X5	-	X5	-
C = Current Payer **O** = Other Payer												